JUDICIAL POLICY IN THE COMMON LAW OF INFORMED CONSENT

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TABLE OF CASES

PREFACE

This thesis was written by someone who has spent an inordinate amount of time in the Accident and Emergency departments of hospitals in more than one of the jurisdictions covered by the research. This is what academics might call primary or empirical research; I call it an extraodinary run of bad luck. The only thing that all of these visits had in common was a recurrent thought about communication between doctor and patient. Even on those visits on which I could be said to have had the use of all my faculties, it was not always easy to understand the procedures recommended. It struck me then that this communication will always be problematic because of a disjuncture between what I might want to be told and what the attending doctor sees fit to tell me. The other disjuncture is one between what the doctor says and what I understand.

I became fascinated by medical law generally through postgraduate studies in Comparative Literature at Wits University, Johannesburg, South Africa; it was also there that I developed a liking for deconstruction of legal texts. From there I embarked on a Master of Laws Degree at the University of Edinburgh where I developed an interest in consent and what the law across the common law world has to say about the consent of a competent adult patient.

There are many people who have given me their support through the process of writing this thesis; they can be divided into two groups: those whose involvement in the work was direct, and those whose involvement was less direct. Of the first group, a special vote of thanks for academic and moral support goes to my supervisors, Professor Ken Mason and Professor Sandy McCall Smith. Others who helped directly are Dr Graeme Laurie whose thoughts on what became Chapter 6 were invaluable, and Alison Britton, who proof-read the entire work *and* provided a shoulder and an ear as a friend and as a colleague.

Of those whose involvement was less direct, but whose support was invaluable, special thanks must be extended to my family for their moral and material support throughout, and for their constant support and communication; to friends and colleagues at the Universities of Edinburgh and Glasgow whose office space and social time I shared (particularly, but not exclusively, Dave Berry, Juliette Casey and Miriam Aziz). Additionally, many thanks to friends, flatmates and ex-flatmates in several countries who were just there for me without even trying. I hope that the work has an intrinsic value and will be of value to the *corpus* of knowledge out there.

Whatever help was given and gratefully received, the work and the responsibility for it, remains my own. The law is as stated on the 1st of August 1999.

MTE

Glasgow, February 2000

INTRODUCTION

INFORMATION DISCLOSURE

1. SCOPE

This thesis is concerned with the common law duty of the medical practitioner to disclose information on the risks inherent in, and alternatives to, medical treatment to which broad consent has been given. This, in brief, is what will be referred to as the 'informed consent scenario'. The term 'medical practitioner' or 'doctor' will be used generically to include the consultant surgeon and physician and the general practitioner,[1] even although the law considers each practitioner in relation to his or her own speciality.[2] The thesis will compare and contrast the positions in the United States of America, England, Scotland, Canada, Australia and South Africa.

Provision of information and communication between patient and practitioner will emerge as fundamental. The plaintiff in disclosure cases will assert that the medical practitioner negligently omitted to disclose a particular piece of information. This will be a question of fact to be assessed by using the patient's notes and through the credibility of the evidence given by the parties involved: the patient, the medical practitioner and expert witnesses called for both sides.

To this extent, it is important to understand the relationship between doctor and patient because they will later become defendant[3] and plaintiff. This introduction is concerned with outlining the scope of the thesis and setting out the comparative methodology to be employed. It is also important at this stage to stress that the thesis is about legal regulation of the practices of the medical profession; hence the power of sanction of the General Medical Council – and analogous bodies in non-British jurisdictions – falls outwith its ambit.

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[1] In eighteenth century England there existed an important political and professional difference between surgeon, physician and apothecary, but these categories may be subsumed under the 'practitioner' head.

[2] Such that, for example, the standard expected of the competent surgeon is different from that expected of a competent general practitioner and specific to the surgeon.

[3] Although the employing Health Authority and not the medical practitioner will be the defendant, if vicarious liability applies.

It is important also to understand how the law views the relationship between doctor and patient because it is that relationship which itself gives rise to a duty of care. Chapter 1 will go on to describe the judicial doctrine of informed consent and to discuss its rationale and certain aspects of its history. From there, one will be able to consider where, in law, the doctrine of informed consent has been held to fit and to analyse why this should be as it is and what policy implications have been brought to bear to make it so. Discussion will begin with the legal position in Canada, because Canada was the first non-American Common Law jurisdiction to adopt the doctrine of informed consent as articulated in some American states. This is in marked contrast to British jurisdictions, which will be discussed next, followed by Australia and South Africa, the most recent jurisdictions to apply the doctrine. Chapter 1 will conclude with a discussion of those policy considerations which have moulded judicial attitudes on the duty of care.

It will have been noted in Chapter 1 that a duty of care exists and that litigation takes place according to the common law of negligence. Chapter 2 will consider the nature of the doctor-patient relationship and will stress the different perspectives from which the parties approach that relationship. It will also highlight the importance of communication in disclosure cases. Having considered why disclosure cases are litigated in negligence and having assessed the nature of the relationship between the parties which gives rise to a duty of care, Chapter 3 will involve a discussion of the *standard* of care that is demanded by courts. It will compare and contrast the legal tests of each jurisdiction which will be brought to bear in the informed consent scenario. Chapter 4 will compare and contrast the same jurisdictions, but this time in respect of their different tests for causation. It will also include a more general discussion of causation in the civil law, which has implications which are broader than those involved in the informed consent scenario itself.

By that point it will have emerged that the evidence of experts and that given by lay persons in such cases are weighted differently by the courts of different jurisdictions. Chapter 5 will therefore consider more fully the precise role of *the expert in disclosure cases*. When the issue is viewed from that perspective, the differences between the jurisdictions are seen as more than mere semantic constructions of judicial tests, but as differences which have practical implications for the outcome of such cases.

That will be a fitting point at which to consider in greater depth the course the law might take in the United Kingdom. The reason for this is that the other jurisdictions have adopted or adapted the doctrine of informed consent, but the courts of the United Kingdom have not. Chapter 6, therefore, comprises several arguments in respect of British judiciaries which speak to the likely direction to be taken by British courts when considering cases brought about within the informed consent scenario. The final chapter will draw together these and other conclusions.

One might also consider the ethical forces behind professional conduct. This will set up a platform from which to discuss the legal forces at work. To illustrate this, Chapter 2 will consider certain elements of the doctor-patient relationship, in order to highlight some of the complexities involved in the consultation which gives rise to litigation and in the litigation itself. This will be done by using the Canadian case of *Reibl v Hughes*[4] as an. This case will be used because the Judgement of the Supreme Court of Canada includes a verbatim reporting of the evidence given by plaintiff, defendant and experts. This ought to set the scene for a discussion of the standard of care demanded by the law of the jurisdictions that are considered.

2. COMPARATIVE LAW

Comparative Law refers to a method rather than a set of principles. When confronted with a novel question, on which there is little or no authority, or on which precedent swings in the opposite direction, a judge will often extrapolate from other cases heard in other jurisdictions by comparison and analogy. This does not mean we have in law a global village. When considering cases in the law of medical negligence and informed consent we are dealing with foreign elements in domestic law as the judiciary is called upon to consider these other systems. In his work on Comparative Law, Schlesinger[5] argued that the legal world can be divided into Civil Law, Common Law and the Soviet Orbit.[6] The systems covered by this thesis are Common Law systems.

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[4] (1980) 114 DLR (3d) 1.

[5] Schlesinger R B *Comparative Law* (2Ed.) 1960. Stevens & Sons Ltd. London. 190 et seq.

[6] Following the end of the cold war, this legal family has changed only in name.

In order for Comparative Law to be an appropriate and useful methodology, the systems being compared must have elements in common. This is because comparison itself does not occur at the level of system but at the level of legal principle. What is important when pleading foreign law is the degree of similarity between systems being compared as well as the degree of generic similarity which lies in the facts of the cases being considered analogous.[7]

These Common Law systems are, at least in part, the progeny of English law from the colonial period. They developed as hybrids of English Common Law and indigenous customary law; they are thus able to include elements necessary to cater for the novelty of new countries during the colonial period in which legal institutions migrated with peoples and had to adapt to the needs of emerging nations.

Common Law countries comprise a clear example of common historical development as well as a fitting example of similar modes of thinking and adversarial legal style. The fact that law evolves from decision to decision suggests that these countries have much in common. Should independently developing Common Law countries adopt broadly similar positions with regard to a particular legal matter, like the doctrine of informed consent, it can be argued that they developed together on the basis of similar principles operative in analogous legal climates. From there it is a short step to argue that because of that similar development, a court is inclined, though not bound, to follow the analogous jurisdiction.

Because the systems under discussion are part of the Anglo-American legal family,[8] decisions made are influential among the jurisdictions. For judiciaries, the matter of informed consent (and other matters) becomes a matter of finding a 'line of best fit' for a novel judicial dictum or test. Counsel, through pleadings, invites the court to adopt a legal principle or argument (such as that of informed consent). For example, in *Sidaway v Bethlem Royal Hospital Governors*,[9] Lord Scarman discussed the appellant's submissions saying in conclusion,

> 'The appellant's second submission is that she has a cause of action which is independent of negligence in the *Bolam* sense. The submission is based on her right to decide for herself whether she should submit to the operation proposed. In effect she invoked the transatlantic doctrine of informed consent.'

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[7] Cf. 1.1. on the 'generic informed consent scenario'.
[8] Especially with regard to court structure and procedure.
[9] [1984] AC 871, 883C-D.

Lord Scarman went on to point out that this constituted a new ground in English law.

Similarly in South Africa in *Castell v De Greef*,[10] paragraph 7A of the plaintiff's claim was restated by Ackerman J as being separate to the claim for negligent performance of surgery:

> 'Plaintiff further avers that defendant was under a duty to warn plaintiff, prior to operating on plaintiff, of the material risks and complications which might flow from such operation, and of any specific alternative procedures which might be followed in order to minimise, reduce or exclude such risks of complications.'

Where a novel ground is averred, what is in issue is a foreign solution to a domestic problem. This is arrived at by the court asking whether a principle of a foreign system can or ought to fit within the given framework and law of the domestic system. This is because there is a difference between pure comparison and the utilisation of the results of that comparison,[11] which could amount to the adoption of foreign law. Courts may, of course, fall back on jurisdictional independence and autonomy to justify not applying aspects of foreign law.

Foreign law appears to a domestic system as fact.[12] The question facing the court is twofold: whether this fact can be assimilated and whether it ought to be assimilated. The effect of this fact scenario is that the foreign law is invoked in the pleadings by the party proposing to rely on it. The party bearing the burden of proof must prove the foreign law as fact, and then introduce evidence that that fact situation ought to fit within the domestic law. This will be a question for both the court, particularly in informed consent cases where so much hinges on the acceptance of the testimony of expert witnesses.

The principle of *stare decisis* remains intact,[13] yet forms of argument are both adopted and adapted to bring precedent in line with another jurisdiction because they are, in the medical sphere, seen to have a basis in ethics[14] and in policy. For example, when it comes to the

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[10] 1994 (4) SA 408, 413E-F.

[11] R B Schliesinger. Ibid. 28.

[12] Schliesinger. Ibid. 41. See also Markesenis *The Gradual Convergence* (1994).

[13] Although consider the *Practice Statement 1966* [1966] 1 WLR 1234 which held that the House of Lords is not bound by its own decisions and hence can, its is argued, change their own law to bring it in line with changed social conditions. Also consider the matter of changing ethical perceptions considered in 1.2.4.

[14] English cases subsequent to *Sidaway* (*Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334 and *McAllister v Lewisham* [1994] 5 Med LR 343 which were High Court decisions) can be seen to subtly alter

informed consent doctrine, England[15] and Scotland[16] adopt a similar position which is different from that adopted by Canada.[17] The Australian position[18] is different again from that in Canada and was latterly adopted in part and adapted in South Africa.[19]

This century, law has become more and more involved in determining the decision-making powers of the medical profession[20] because medical practice is out-pacing law and because more is demanded from medicine.[21] This means that the law has more to regulate. Where Teff considers the 'increasing involvement of law with medicine', he considers 'involvement' to be the same as 'encroachment' or even 'engagement'[22] in a context in which court declarations of lawfulness are more commonly sought. This ought also to be seen against the exponential growth of actions for negligence.[23] With the law taking over to a certain extent, Law becomes the 'symbolic representation of the limits of medicine's authority',[24] beginning with the law's categorisation of the nature of the relationship between doctor and patient – in particular its determination that, in law, a duty of care is owed by the medical practitioner to the patient.

Sidaway on informed consent, showing the beginnings of the 'slippery slope' which will be argued in Chapters 3 & 6 of this thesis.

[15] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 HL.

[16] *Moyes v Lothian Health Board* 1990 SLT 444, [1990] 1 Med LR 463.

[17] *Reibl v Hughes* (1980) 114 DLR (3d) 1.

[18] *Rogers v Whitaker* [1993] 4 Med LR 79, [1992] ALJR 47.

[19] *Castell v De Greef* 1994 (4) SA 408.

[20] See *Re S (Adult: Refusal of Treatment)* [1992] 3 WLR 806 and *R v Cox* 12 BMLR 38.

[21] This is because the ability of medical science to diagnose far outpaces its ability to treat, particularly in the field of human genetics.

[22] Teff 16.

[23] *The Economist*. August 19th 1995. '[P]ay-outs by hospitals have risen from nothing five years ago to £125 m in 1994-95' with a further £1 billion 'in the pipeline.'

[24] Teff 4, quoting R Zussman *Intensive Care*. 1992. Chicago University Press. Chicago. 183.

CHAPTER 1

IN NEGLIGENCE WE TRUST

1.1. INFORMED CONSENT IN THEORY

The purpose of this chapter is to explore the informed consent scenario as it occurs in the jurisdictions covered by this thesis. This chapter will therefore outline briefly those generic facts which may give rise to a legal claim under the *informed consent* head. It will go on to outline the theory behind what has become a legal doctrine and then look at where the doctrine fits in law. The reason for so doing is that, originally, such generic facts gave rise to an action in battery in some American states. By the time the doctrine moved to Commonwealth jurisdictions, it was already litigated under the negligence head. However, for policy reasons courts still found it necessary to exclude assault and battery.

This chapter will first consider the Canadian position because Canada was the first non-American jurisdiction to adopt the doctrine. By way of contrast and due to chronology, British jurisdictions will then be considered, followed by Australia and then South Africa. The doctrine was accepted in a modified form in Canada in *Reibl v Hughes* in 1980, rejected in England in *Sidaway* in 1985 and in Scotland by *Moyes v Lothian Health* Board in 1990, accepted in Australia in *Rogers v Whitaker* in 1993 and adapted in South Africa in *Castell v DeGreef* in 1994. By way of conclusion, this chapter will consider other aspects of the law of negligence which are pertinent to the informed consent scenario and then discuss those judicial policy considerations which are brought to bear in the case law.

In the interest of focus, this thesis will be confined to situations in which a legally competent patient has given general consent to a medical or surgical procedure; as a result of that procedure, the patient will have suffered some form of legally recognised injury. Instances involving plaintiffs who lacked competence to consent because of their age or mental capacity will be excluded. In the cases being considered, the plaintiff's allegation would be that the

injury was in some way linked[25] to their uninformed consent to that procedure. The plaintiff will be seeking restitution (that is non-punitive damages) as compensation for the injury suffered.

The case law on the topic indicates that such actions lie in the law of torts and with the exception of South Africa, in the tort of negligence. This has been the case for some centuries,[26] yet well into the present century arguments have persisted on the applicability of the torts of assault and battery, as have arguments in which a contractual context has been suggested. Each Commonwealth jurisdiction is specific because the law has developed differently. Before considering these differences it is necessary to answer the question 'what, in law, do we mean by *informed consent*?'

1.1.1. INFORMATION

Medical and surgical procedures constitute *prima facie* assaults in the civil law, unless authorised by the patient's consent.[27] Consent will probably not be given for an operation to be performed improperly. Nevertheless, any surgery carries inherent risks irrespective of its quality. Knowledge of risk is important if it could affect the decision whether and in which way to receive treatment.[28] In the event of such a risk eventuating, the pursuer may claim that his consent was vitiated by the surgeon's failure to warn of that risk; he would allege that had the information been given, consent to the operation would have been withheld. Any such claims are now normally framed in negligence, a route which raises the question of the standard of care and the wrongfulness of the omission.

The doctrine of informed consent originated in America. Its application seeks to balance the practitioner's legal duty to provide information with the patient's right to make an

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[25] See Chapter 3 on causation.

[26] In *Sidaway* Lord Diplock, considering the *Bolam* test (Cf. 3.2.2.1. & 4.2), noted that 'it may be of interest to note that as long ago as 1767 in Slater v. Baker, 2 Wils. 359, a suggestion that where the injury was caused by surgery the form of action lay in trespass vi et armis was rejected with scant sympathy by the Court of King's Bench.'

[27] The position is different in the criminal law in which evidence of 'evil intent' will be required by the court. The medical practitioner acting in good faith will not fall foul of the criminal law, but may find that the civil law provides the patient with a remedy.

autonomous choice. Perhaps the most fitting definition of the doctrine is in *Harnish v Children's Hospital Medical Center*:

> ' ... a physician owes to his patient the duty to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to an intelligent decision by the patient whether to undergo a proposed procedure.'[29]

Mr Justice Frankfurter had observed in *Tiller v Atlantic Coastline Railway Co.*[30] that in law a 'phrase begins life as a literary expression, its felicity leads to its lazy repetition, and repetition soon establishes it as a legal formula' removed from its original context.[31] The *doctrine* of informed consent has, through repetition and elaboration in the last four decades, evolved and expanded.[32] As jurisdictions other than America adopt the doctrine, evolution in America can be used either as a predictive mechanism in Commonwealth countries or as a basis for the justification of 'slippery slope' fears.

The doctrine of informed consent will initially be examined from theoretical and rhetorical points of view as background to considering its legal interpretations.[33] This will begin with an examination of the etymology[34] of the words which make up the term, move through its American development to examine its elements and then consider the legal positions across the Commonwealth.[35]

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[28] J R Matthews *Quantification and the Quest for Medical Certainty*. 1996. Princeton University Press.

[29] *Harnish v Children's Hospital Medical Center & others* 387 Mass. 152; 439 N.E.2d 240, 155. See also *Williams v Menehan* 379 P.2d 292 (1963).

[30] 318 US 54, 87 L Ed 610 (1943), 618, quoted by M D Kirby 'Informed Consent: What Does it Mean?' (1983) [9] *Journal of Medical Ethics* 69.

[31] Cited in Mason & McCall Smith. *Law and Medical Ethics* (5th edition) 278.

[32] It has also been misunderstood, particularly by the medical community, as a catch-all phrase encompassing all matters of medical information. Consider, for example, the subject matter of an article in the *British Medical Journal* which ought properly to have been considered an issue of confidentiality (to which principle, consent is an exception), rather than one of informed consent: Catherine A Hood, Tony Hope & Phillip Dove, 'Informed Consent in Medical Research – videos photographs and patient consent', *BMJ* No 7136, Volume 315, Education and Debate, Saturday 28 March 1998.

[33] Parts of what follows (here and in Chapter 3) have been updated from an article published in the South African Law Journal: See Earle, Murray 'Informed Consent: Is there Room For the Reasonable Patient in South African Law?' (1995) 4 *South African Law Journal* 629 (Appendix A).

[34] From Eric Partridge: *Origins: a Short Etymological Dictionary of Modern English*. 1958. Routledge & Kegan Paul. London. 228-9, 604-5.

[35] In subsequent chapters.

1.1.2. ETYMOLOGY

Both the verb and the adjective *inform* are rooted in the Latin *forma*, meaning to give shape to a[nother] person's thoughts. *Consent* derives from the Latin *sensus* meaning to be of an opinion and hence to express that sentiment. It was then developed by the medieval French *consintire*. From that, the verb *to consent* took on a connotation of collaboration, meaning to be of the *same* opinion. In usage, *consent* is restricted to the giving of permission or the accepting of a proposal and always implies the power not to consent.[36] *Informed consent* can be said to consist of causing someone to receive knowledge, which forms the basis for their decision to give consent. In law it is a matter of the wrongfulness of omitting to do so.

The etymology suggests that the practitioner's art incorporates that of persuasion within the partnership - to convince the patient in favour of a certain course of treatment even at the expense of understanding. Etymology cannot explain the practices of the medical community, but it is an interesting perspective from which to consider the doctor-patient relationship and the communicative context in which consent is given and information supplied; this is a context in which the dimension of power is constantly operative. The medical practitioner gives form to his medical opinion, explaining jargon and technical terms. The patient uses this information to form his part of an opinion which is (ideally) formed jointly with the practitioner. This is different from agreeing with the practitioner's proposal and it is clear that this difference in perception between patient and practitioner often becomes an issue in so-called informed consent cases.

The duty of the practitioner is twofold: to inform and to obtain consent to the treatment proposed. One must consider whether there is a difference between the information actually given and the information required in law for an adequate understanding of the treatment proposed. Where negligence is alleged in jurisdictions which have adopted the doctrine as law,[37] that negligence will be based on a difference between the information actually given to

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[36] In the case of adults. In the case of minors, the power to consent may not carry with it the power to refuse treatment. See the *Gillick v West Norfolk and Wisbech AHA* [1985] 3 All ER 402, [1986] AC 112 and the Age of Legal Capacity (Scotland) Act 1991. This falls outwith the ambit of this thesis.

[37] Or indeed in those which have adopted a subjective patient standard for causation. This will be discussed in Chapter 4.

the patient and the information which the patient alleges was required to render the consent complete. The legal position is in constant flux, but central to the doctrine is the precept that,

> 'unless a doctor discloses to a patient certain types of information before undertaking a ... procedure, the patient may collect damages from the doctor if he or she is injured by the procedure, even though the procedure itself was properly performed.'[38]

This chapter will go on to explain that this will rest on the plaintiff-patient establishing the elements of a claim under the laws of torts or delict.

1.1.3. PHILOSOPHICAL ORIGINS AND AMERICAN LEGAL DEVELOPMENT

In *Ellis v Wallsend District Hospital*, Kirby J said, 'Since Hippocrates and Plato, it has been axiomatic that physicians must give no prescription until they have obtained the patient's understanding and consent.'[39] According to Hodgkins JA, the doctrine derived from the need, in pre-anaesthetic medicine, to encourage the patient. In *Kenny v Lockwood* in Canada,[40] he quoted with approval Wilmot C J in *Slater v Baker & Stapleton*, who had said that 'it is reasonable that a patient should be told what is about to be done to him that he may take courage and so put himself in such a situation as to undergo the operation.'[41] The rationale of the rule remains primacy of patient autonomy. In that context this means the patient is able to exercise the right to choose whether or not to undergo treatment at all and then to choose among available treatment options.[42]

The term informed consent was first used in *Salgo v Leland Stanford Jr. University Board of Trustees*[43] in 1957 and *Natanson v Kline*[44] was the first case in America to take the matter in negligence rather than in trespass. The doctrine was initially a hybrid legal concept, uniting the torts of negligence and battery, before becoming grounded in negligence. *Natanson*

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[38] Charles W Lidz et al. *Informed Consent: a Study of Decision Making in Psychiatry*. 1984. The Guildford Press. New York. 2.
[39] [1990] 2 Med LR 103, 113 Col.i. Here Kirby J cited Plato, *The Laws, Book IV* at 720. Whether or not he was citing Plato correctly or aptly does not alter the principle on which Kirby J was basing his judgement.
[40] [1932] 1 DLR 507 (Ont. 1932).
[41] *Slater v Baker and Stapleton* (1767) 2 Wils KB 359, 95 ER 860, *Kenny v Lockwood* [1932] 1 DLR 507, 518.
[42] On the rights issue, see 6.3.1.
[43] 154 Cal. App. 2d 560; 317 P.2d 170 (Cal, 1957)

v Kline affirmed the *Salgo* coinage in 1960 and expanded the ruling in *Schloendorf v Society of New York Hospitals*[45] to hold that self determination is a fundamental premise of Anglo-American law and that substituted judgement, artifice or deception by a doctor are not always permissible. It went on to rule in favour of an entitlement to 'full disclosure of risks, benefits and alternative treatments ... both in therapy and in medical experimentation, except in emergencies or in cases where the patient is incompetent.'[46]

In 1972, the court in *Canterbury v Spence*[47] discussed the rules on informed consent in terms of the patient's rights: the patient has the right to know of risks, benefits and alternatives to the treatment proposed. In describing the extent of this right to know of certain 'material' risks, it was held in *Cobbs v Grant*[48] that 'a patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications' and that 'a mini-course in medical science is not required.'[49] This is a position with which Commonwealth jurisdictions concur. Similarly, in *Canterbury v Spence* it was established that 'respect for the patient's right of self determination on a particular therapy demands a standard set by law for a physician rather than one which physicians may or may not impose on themselves.'[50]

In England the standard is a medical one,[51] despite the fact that in his dissenting judgement in *Sidaway* Lord Scarman stated that a doctor's duty to supply information on risks and alternatives stems from the patient's right to that information.[52] This is significant because it is a dissenting judgement yet is cited by the British Medical Association as the basis for an ideal mode of practice. It indicates a reasoning on which the professional standard can be put to the use of the patient in the United Kingdom. With this comes a gravitation towards the adoption of a form of the doctrine of informed consent.[53]

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[44] 186 Kan 393, 350 P.2d 1093 (1960).
[45] 211 N.Y. 125, 105 N.E. 92 (1914).
[46] 186 Kan 393, 350 P.2d 1093 (1960); LEXIS.
[47] 464 F.2d 772 (1972).
[48] 502 P.2d 1,11 (Cal. 1972).
[49] See 3.3. on materiality of risk.
[50] 784.
[51] Cf. 3.2.
[52] *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871, 888.
[53] See 3.2.1., 5.4. and 6.3.

Information on risks and alternatives is central to this inquiry because medical treatment involves risk.[54] Despite the fact that judges assert that they will not be dictated to by statisticians,[55] knowledge of numerical probabilities can be very important to the patient[56] and to the law. Because it is possible to calculate the prevalence of risks involved in medical interventions, public awareness plays an important role, to the extent that a patient may be expected to ask questions like 'what chance is there of something going wrong?'[57] Yet in England and Scotland it remains at the discretion of the practitioner whether to disclose these risks if not asked. Withholding information because of the remoteness or triviality of the risk places the practitioner in jeopardy of a particular patient asserting, with hindsight, that he would have declined treatment had he been informed.

What the patient is told still depends largely on the consensus of the medical community and the question of determining relevance remains one for the practitioner to take, often at his peril. It is at that point that consensus of doctor and patient may break down and persuasion must take over. Consensus may also break down after the fact where, for example, the patient asserts with hindsight that, had he had the information which was lacking, he would not have undergone the treatment and hence not have suffered the injury. This proof of causation is a necessary element of a tort claim whether or not it is based on consent.

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[54] *Sidaway* considered the materiality of a risk of 1:100 and *Rogers v Whitaker* of 1:14,000.

[55] In the criminal context, see *Regina v Adams*, *The Times*, 9 May 1996 on statistics. In that case it was decided that juries are not to apply mathematical formulae. Lord Justice Rose held, 'Jurors evaluated evidence and reached conclusions not by means of formulae, mathematical or otherwise, but by the joint application of their individual common sense and knowledge of the world to the evidence before them.' This suggests that we cannot take formulae and probabilities as particularly decisive.

[56] See J Rosser Matthews *Quantification and the Quest for Medical Certainty*. 1996. Princeton University Press.

[57] F J Dodd et al, 'Consensus in Medical Communication' (1993) 37:4 *Soc. Sci. Med.* 565-569, 565.

1.1.4. ASSEMBLY

As a doctrine, informed consent developed as a mechanism for extending the civil liability of medical practitioners and for promoting patients' rights. This implied a redefinition of the fiduciary relationship between doctor and patient.[58] While the requirement of consent has a long history, interest in its quality is as recent as four decades. In most American jurisdictions it is the responsibility of the physician to give information, while to varying degrees in Commonwealth jurisdictions the expectation is that the patient will request it. For example, in the contract case of *Eyre v Measday*, Slade LJ considered patient expectations and the remoteness of a sterilisation operation failing and said, 'I am afraid that, in my view, if they had wanted a guarantee of the nature which they now assert, they should have specifically asked for it.'[59]

According to the informed consent doctrine, the omission to inform of material risks prior to the procedure constitutes negligence. A risk is said to be material if 'a reasonable person in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk in deciding whether or not to forego the proposed treatment.'[60] In the opening chapters of their work on decision-making in psychiatry, Lidz et al[61] divide informed consent into certain basic elements, which must all be present in the doctor-patient interaction. These are listed as information, competency, understanding, voluntariness and decision:[62] a patient must be legally competent to make a voluntary decision regarding treatment on the basis of an understanding gained from information given by the medical practitioner.

The concept of *interaction* is central here; its quality determines the extent to which the patient is able to assimilate and understand the medical information communicated. This highlights a number of facets which are important to the legal inquiry: the patient's competence

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[58] Caroline L Kaufmann, 'Informed Consent and Patient Decision Making: Two Decades of Research' (1983) 17:21 *Soc. Sci. Med.* 1657-64, 1660.

[59] [1986] 1 All ER 488, 495-496. It is acknowledged that this is a difficult case from the point of view that many parts of the judgement were based on the first instance decision of *Thake and another v Maurice* [1984] 2 All ER 513 which was overturned by the Court of Appeal in *Thake and another v Maurice* [1986] 1 All ER 497. However, this does not alter the point being made here.

[60] *Canterbury v Spence* 772.

[61] Charles W Lidz et al Ibid.

to understand, whether he ought to have understood, whether the doctor can reasonably expect this patient to have understood and whether this patient actually understood. Answers to these questions are material to whether there has been consent between the litigants.

An American test for competency may be found in *Grannum v Berard*.[63] The *Grannum* test for asserting or testing the competence of the patient is the same as that for capacity to contract: did a person at the time of agreement have 'sufficient understanding of the nature, terms and effect of the agreement'?[64] This is not a test of the rationality of the decision actually taken, but of the patient's capacity to comprehend the information. With this test a practitioner may seek to justify having withheld information because the patient lacked the competence to understand it. Alternatively, a patient may argue in favour of the communication of that information on the ground that he possessed the necessary degree of competence.[65]

Since Roman law times,[66] freedom of agreement has been important because it derives from freedom of the will. In all legal agreements there is the need for unforced and informed consent as a declaration of willingness. This gains enhanced importance in both invasive and non-invasive medical procedures where the absence of information (whether through deliberate or negligent omission) vitiates the will, and possibly the consent, of the patient, and could give rise to a legal cause of action.

Commonwealth and American courts focus on patient autonomy, especially with regard to refusal of treatment, yet they differ on how much information ought to be disclosed to the patient. Most American jurisdictions require of a doctor responsible disclosure regarding

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[62] Charles W Lidz et al 3, 20-23.

[63] *Grannum v Berard* 70 Wash. 2d 304, 307, 422 P.2d 812, 814 (1967). See Montange, Charles H. 'Informed Consent and the Dying Patient.' (1974) 8 *Yale Law Journal* 1632.

[64] Nieuw, A. D. 'Informed Consent.' *Medicine and Law*. (1993) 12: 125-130, 127. We see here the beginnings of the contractual of the doctor-patient relationship, which will be considered in 1.2.2.3, 2.4.2. 3.7 & 5.4.4.

[65] There is a rebuttable presumption of competence: see, for example, *F v R* (1983) 33 SASR 189.

[66] Honoré, T. 'Hermogenianus on Privity and the Scope of the Law of Contract' (1991) *Current Legal Problems* 135.

the probable consequences and dangers falling within his knowledge.[67] Consent based on such disclosure will be said to have been informed.

The practitioner's duty is to reach and give a diagnosis and to discuss possible treatment and the risks involved in that treatment. The patient's role is to use this information within his own value system to make a choice. This does not hand the matter over to the patient because the practitioner still holds the power of diagnosis and advice and because of the argument that informed consent has a grounding in persuasion. However, given that the practitioner has the opportunity to abrogate the power of decision to the patient, the practitioner under time pressure[68] has little time to argue and this does, in effect, hand the power over to the patient. It remains a power grounded in knowledge and is, in the present argument, illusory when the patient holds such power on the basis of an inadequate understanding of the medical matter in question.

The hospital or consultation room is often perceived as a coercive environment. In this context the patient seldom reflects adequately on the written consent which is considered necessary.[69] Seen this way, the art of persuasion exercised by the busy practitioner abrogating illusory power to a patient within a coercive environment comes close to undue influence; it cannot be seen as approaching the ideal of the understood consent of the autonomous patient.

Elaine Scarry wrote that legal consent has attached to it facets of contract, signature, partnership, promise, waiver, warranty and elements of the relationship between the subject and property.[70] She considered consent in surgical operations in terms of consent to injury and bodily violation, citing the much-quoted Judge Cardozo in *Schloendorff*,[71] who considered that 'each adult of sound mind has a right to determine what shall be done with his body.'[72]

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[67] *Williams v Menehan* 379 P.2d 292 (1963).
[68] Such as the houseman or the doctor in a busy practice
[69] J R Matby & C J Eagle 'Informed Consent for Clinical Anaesthesia Research' in (1993) 40:9 *Canadian Journal of Anaesthesia*. 891-6, 891.
[70] Elaine Scarry 'Consent and the Body' (1990) 4 New Literary History 867, also in Dickens B M *Justice Beyond Orwell*. 1985. Les Editions Yvon Blais Inc. Montreal. 243.
[71] 211 N.Y. 125, 105 N.E. 92 (1914) at 97.

An important facet is the *disclosure* of risks inherent in, and alternatives to, the procedure proposed. This lends particular importance to the disclosure document. A fiduciary relationship would give rise to disclosure requirements on the part of the practitioner and in America both common and statutory law demand increasingly comprehensive disclosure. This disclosure generally has no formal requirements, but while implied consent is accepted in certain circumstances, implied disclosure is 'somewhat difficult to conceive'.[73]

Even so, disclosure should ideally be both written and oral, with the document following conversational disclosure of the treatment's reasoning, its methods and the risks and alternatives attached to it. In the partnership model of doctor-patient interaction, this ideal has become more developed; yet that ideal is still prone to be seen within the profession as a legal instrument and as promoting mistrust. This, in turn, encourages defensive medicine.

Factors which determine the scope of the obligation to inform are pivotal, especially in the expansion of the doctrine. The test for materiality is a subjective one because under the doctrine of informed consent the amount and quality of disclosure required for understanding varies with each individual set of circumstances. Disclosure ought to be made in a way which the particular patient understands and is able to assimilate, such that any decision made on the basis of the information given is autonomous and grounded in true self determination. This argument expressly challenges that which holds disclosure to be a mere formality and those which contend that an objective test for materiality is to be preferred.[74]

1.2. Liability in the Tort of Negligence

The Australian case *Re Katherine Mary Golski*[75] was not an informed consent case yet was a case of alleged medical negligence. Kelly J defined a cause of action as being,[76]

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[72] Also *Canterbury v Spence*.
[73] F F W van Oosten 'Disclosure Documents and Informed Consent: the Pros and Cons.' (1993) 12 *Medicine and Law* 651-656, 651.
[74] See 3.3.
[75] 1987, Lexis. Federal Court of Australia, Australian Capital Territory District, 16 April 1987.
[76] Citing the English cases of *Read v Brown* (1888) 22 QBD 128 per Lord Esher MR at 131 and *Cooke v Gill* (1873) LR 8 CP 107 at 116, per Brett J.

> ' ... every fact which it would be necessary for the plaintiff to prove, if traversed, in order to support his right to the judgment of the Court. It does not comprise every piece of evidence which is necessary to prove each fact, but every fact which is necessary to be proved.'

In England in *Letang v Cooper*[77] Lord Diplock defined a cause of action as 'simply a factual situation the existence of which entitles one person to obtain from the court a remedy against another person.' A consideration of the *facta probanda* of a case is useful to establish the applicable cause of action in informed consent cases.

One should consider the doctrine in the context of the relationship between doctor and patient as well as between plaintiff and defendant. A patient suffering injury following medical treatment may have a legally recognised claim in damages against the person(s) responsible for the injury. In order to understand that this claim lies in tort there are four possible causes of action which need to be considered.[78] They will be outlined here briefly before looking at each jurisdiction individually.

An action based on breach of contract is uncommon yet not unknown. If it does occur, it will be an action taken either in conjunction with or in the alternative to an action in negligence. This is because the two actions serve different ends: the action based in contract for recovery of patrimonial loss and the action based in delict or tort for the recovery of damages.

A second possibility is an action based on the breach of a fiduciary duty. Although some jurisdictions characterise the doctor-patient relationship as a fiduciary one, such an action is a more remote possibility. A fiduciary duty remains one which the law may suppose to have arisen from the special relationship between the parties. This relationship requires the doctor to disclose to the patient any conflicting interests as well as to act in the patient's interests.

In the third place, medical treatment involving physical contact with the patient and without that patient's consent in any form constitutes an assault (technically a battery) for

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[77] [1965] 1 QB 232, 242-3.
[78] See *Thake and Another v Maurice* [1986] QB 644, [1986] 1 All ER 497.

which an action in trespass to the person may be brought by the patient.[79] This would be elided by consent of any sort if the action were framed in tort. Trespass had been the preferred option in America in which lack of informed consent gave rise to such an action, thereby conflating the torts of medical negligence and medical trespass. The action, after *Salgo v Leland Stanford Jr Board of Trustees* and *Natanson v Kline* is now in negligence. It is suggested here that one of the rationales for this separation is to expand the liability of medical practitioners in respect of information disclosure. Whereas the category of assault was always able to cover incidents in which no consent was obtained at all, a niche was sought which would cover instances in which there ad been a general consent to the nature of the procedure, but that consent was given in the absence of information on the very risk which eventuated and caused injury. This niche was to be negligence.

It is argued that the main reason for supplying patients with information on their condition, diagnosis, prognosis and treatment is respect for the patient's autonomy. With that information, the patient is better able to make a balanced assessment of their own condition and options. Given information on risks and alternatives, the patient is better able to exercise his or her autonomy. It is argued that for this reason the medical practitioner has a duty to provide the patient with that information. If that forms part of the standard of care in law, it follows logically that the proper place for the action is in negligence.

Use of the category of battery in the context of medical treatment can also promote the value of patient autonomy because it proscribes physical contact without consent – whether or not in the context of medical treatment. There is a problem with this, however. If consent was given to the general procedure, but was to be deemed completely ineffective because of lack of a particular piece of information, that would render the medical practitioner liable in battery, to which reasonable practice is no defence.[80] It follows, therefore, that if courts were to adopt the policy of expanding the liability of medical practitioners for omissions to inform patients, and if

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[79] *Chatterton v Gerson* [1981] QB 432, [1981] 1 All ER 257, in which the concept of battery was considered as available in the absence of general consent. With general consent present, the battery possibility no longer exists. Bristow J held that the negligent failure to disclose inherent risks would not in itself vitiate consent. This was followed in *Hills v Potter* [1983] 3 All ER 716, 728, [1984] 1 WLR 641, 653 (in which Hirst J agreed that the proper cause of action is in negligence), and in *Sidaway*.

that omission spoke to matters of consent, courts would also have to formulate policy to limit liability in line with judicial policy.

Schultz argued that, 'there are many aspects of the medical care relationship which do not fit comfortably within the battery model.'[81] In particular, she considers that, 'Doctors lack the antisocial motivation usually associated with intentional torts such as battery' and points out that the in the doctor-patient relationship, the touching differs from the conventional battery model insofar as some form of consent had already been given, albeit arguably defective consent.[82] She goes on to argue that if courts were to hold that the lack of information invalidated the consent given, this would be 'unduly harsh' on members of the medical profession. She cites case law throughout and there is an echo of this sentiment in Lord Scarman's judgement in *Sidaway*, in which his lordship had said that 'it would be deplorable to base the law in medical cases of this kind on the torts of assault and battery.'[83]

In addition, the policy adopted by the courts of all jurisdictions discussed here is one which allows a greater breadth of defence to members of the medical profession. It allows reasonable care to be an absolute defence in the case of British jurisdictions or to speak in argument for the defence in the case of Canada, Australia and South Africa. This policy would appear to be a cogent policy given the informed consent scenario. It is usually the case that surgery or treatment was recommended and gave the best chance of recovery yet carried certain low-probability risks which were not disclosed.

The legal wrong, therefore, is a non-physical one. It is true that harm is an essential element of the delict or tort, and it is self-evident that without the treatment which carried the risk which harmed the patient, that patient would not have suffered harm. However, the legal wrong in such cases is an omission to inform, rather than physical contact with the patient. Expressed semantically, the plaintiff asserts that had they had the information which was

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[80] On this point in relation to American decisions, see Marjorie Maguire Schultz. 'From Informed Consent to Patient Choice: a New Protected Interest.' (1965) 95(2) *Yale Law Journal*. 219, 224.
[81] Ibid. 225.
[82] Ibid.
[83] [1984] AC 871, 883.

lacking, they *would not have* consented; the plaintiff does not argue that they *did not* consent. Expressed this way, it would seem entirely inappropriate to consign the facts to an action which requires that the plaintiff *had not* consented rather than that *they would not have* consented had circumstances been different. As Schultz puts it, 'physical contact is too literal a demarcation for what is a much broader, non-tangible interest in patient choice.'[84]

If the purpose of the provision of information is to protect autonomy, one would have to ask whether the context of that protection involves the sort of physical contact that usually gives rise to assault cases. The context is the doctor-patient relationship which, it is argued, does not usually give rise to assault cases during the normal course of treatment. Therefore, the provision of information should be seen in the context of a duty of care owed by a doctor to a patient. That said, some form of physical touching is still necessary because without injury, no issue of informed consent could arise in negligence either. It remains the case, however, that the legal wrong is a non-event; it is the omission to provide information which is required by the applicable standard of care.

Having rejected the category of assault, the remaining possibility is that the failure to provide information concerning the nature and risks of the procedure constitutes negligence if there is established in law that such a duty existed, that it was breached and that as a result the plaintiff suffered injury.[85] Having considered where liability might lie, it remains to consider one of the jurisdictions covered by this thesis by way of example and as a starting point. Canada has been chosen because the story is at its clearest there and because Canada was the first Commonwealth jurisdiction to adopt the American doctrine. The timing is important here. By the time the Supreme Court of Canada adopted the doctrine in 1980, the facts giving rise to an action based on information disclosure had already relegated the action to the category of negligence in the United States. As such the need to consider why the category of assault had less applicability in consent cases was less pressing. This, however, did not prevent Canadian

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[84] Ibid. 229.

[85] In *Lanphier v Phipos* (1838) 3 C & P 475, 479, Chief Justice Tindal instructed an English jury, 'Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake to use the highest degree of skill. There may be persons who have higher education and

courts from considering the matter, though it did, arguably, obviate the need to devote as much attention to the rationale for the exclusion of assault.

1.2.1. THE CANADIAN STORY

Discussion might begin with the example of Canada for chronological reasons, and because this thesis will argue in favour of the Canadian approach, before applauding some facets of the British approach. It will also become apparent in subsequent chapters that English tests for causation within the informed consent inquiry, approximate to the Canadian model.

It is useful to the present discussion to begin with the cases of *Kenny v Lockwood*[86] and *Marshall v Curry*[87] because those cases considered the law as it was in America in the 1930s. At that time Canadian and American law were very similar in this area. Courts were concerned to distinguish between the tort of negligence and the torts of assault and of battery as well to consider such matters as flowing from what the court considered to be the nature of the physician-patient relationship.[88]

Central to the question *quid juris* is determining what might have rendered consent invalid or incomplete. In *Kenny v Lockwood* one of the issues facing the court was that of fraud and misrepresentation which were alleged to have vitiated the consent given to the surgical operation. Hodgkins JA thought it unfortunate that such an argument had not been given up because he found no evidence of fraud; the relationship set up between patient and surgeon gave rise to a duty of care.[89] It was held that, in cases such as this, actual deceitful fraud made knowingly or recklessly and without belief in its truth had to be proven.[90]

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greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill, and you will say whether in this case, the injury was occasioned by the want of such skill.'

[86] [1932] 1 DLR (3d) 507.

[87] [1933] 3 DLR (3d) 260.

[88] On this matter *Kenny v Lockwood* cited the English case of *Nocton v Lord Ashburton* [1914] AC 942, indicating a split allegiance between English precedent and American legal development.

[89] 509.

[90] This falls outwith the ambit of the present thesis in that, as indicated in the introduction to this chapter, we are considering ill-informed consent which is in itself incomplete, rather than a total lack of consent or consent

The court in *Kenny* went on to argue that it had 'to take the operation as having been skillfully done' which 'makes it more than usually difficult to define the exact limits of the duty which arises in such a situation.'[91] The next half century of legal development was to carve a legal niche for informed consent in Canada. Staying with the present case, it is noteworthy that Hodgkins JA drew heavily and with approval on English and Scottish precedent. In particular he cited *Edgar v Lamont*[92] in which Lord Salvesen had noted that there existed a series of English decisions,

> 'to establish the proposition that a patient is entitled to a direct action *ex delicto* against a doctor for professional incompetence or negligence... . It seems to me that a clear ground for action is that a doctor owes a duty to the patient, whoever has called him in and whoever is liable for his bill, and it is for breach of that duty that he is liable.'[93]

The court was keen to distinguish such actions from actions which could be founded in breach of contract by stating clearly that the action is based on the duty of care rather than on the notion of contractual engagement or fee. The court did not determine which tort was more applicable, although it did suggest that an action lay in negligence by holding that the relationship gave rise to a duty of care.[94]

In *Norberg v Wynrib*[95] the Canadian Supreme Court found a doctor who traded prescriptions for sex liable in battery on the basis that consent was negated by the equitable doctrine of unconscionable transactions. This had previously been confined to contracts founded on unequal bargaining power, but following *Norberg v Winrib*, the basis became fiduciary. McLachlin J said, 'I do not find that the doctrines of tort or contract capture the essential nature of the wrong done ... . Only the principles applicable to fiduciary relationships and trust, not self-interest, was at the core of the fiduciary relationship ...'.[96]

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in the contractual context which would be vitiated through the fraudulent misrepresentations of fact made by one of the contracting parties.

[91] 510.

[92] [1914] SC 277, 279.

[93] Cited in *Kenny v Lockwood*, 518.

[94] A duty of care also exists in the law of contract. Consider, on this point, the judgement in *Breen v Williams* [1995] Med LR 385, in Australia in which Brennan J said, 'In the absence of special contract between a doctor and a patient, the doctor undertakes by the contract between them to advise and treat the patient with reasonable skill and care.'

[95] (1992) 92 DLR (4th) 449, 484.

[96] 485.

As an intentional tort, trespass to the person or battery is actionable *per se*.[97] This contrasts with an action in negligence in which proof of actual injury is a necessary element of the claim.[98] A further difference is that in battery cases, causation is easier to prove because battery is an intentional tort. Conversely, in negligence the test is one of forseeablilty in personal injury cases. The tort of assault is also actionable *per se* and is a crime: the same principles which apply to battery apply to assault. The difference between the two torts is that battery concerns actual force while assault includes 'both the threat and the application'.[99]

In *Marshall v Curry*[100] the court considered assault and battery in the context of consent; in that case the action was brought in the alternative. The plaintiff claimed that the defendant committed battery by removing a testicle without his consent and while the plaintiff was under anaesthetic. In the alternative, he alleged that the defendant was negligent in not informing him that it might become necessary to remove a testicle while treating a hernia. A third alternative alleged that removing the testicle under those circumstances constituted an assault.[101] The professional skill of the surgeon was unchallenged at trial and the action was confined to one in assault.

The court found that there had been neither express nor implied consent to the removal of a testicle but that a defence of necessity would succeed.[102] The court considered the law in America on this matter because of a lack of Canadian precedent.[103] From those cases Chisholm CJ found support for the principle that while surgical operations can be contracted for, in such cases anaesthesia 'renders the patient unable to consent at the very time that the rule of common law required that his consent be obtained ...'.[104] It was held that in such circumstances, the

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[97] It is also a crime. See Markesinis & Deacon. *Tort Law* (3 Ed.) 245 et seq. on the difference between the torts.
[98] Except where the defence of *volenti non fit iniuria* is available. See 3.3.3. & 3.4.2. on the position in South Africa. In negligence actions based on consent, the existence of injury is usually uncontroversial when considering the merits of the case; it's importance becomes elevated when considering damages and quantum.
[99] Markesinis & Deacon 355.
[100] [1933] DLR (3d) 260.
[101] *Marshall v Curry* [1933] DLR (3d) 260, 260-261.
[102] 264.
[103] Citing, among other cases, *Pratt v Davis* (1906), 225 Ill. 300, *Mohr v Williams* (1905), 95 Minn. 261, *Brennan v Parsonnet* (1912), 83 N.J. Law 20 and *Schloendorff v New York Hospital* (1914), 211 N.Y.R. 125.
[104] Chisholm CJ at 270 citing *Mohr v Williams*, 95 Minn 261 at 23-26.

doctor was transformed into the patient's representative and the original contract, if it existed, became irrelevant.

On the basis of the American cases and similar cases in the province of Quebec, Chisholm CJ was able to hold that consent, which may be express or implied, had to be obtained where possible and that this applied to both surgery and examination. Without such consent the operation or examination was technically an assault.[105] The difference between assault and negligence was succinctly stated in *Hershey v Peake* and quoted by Chisholm CJ in the present case:

> 'The distinction ordinarily between an unauthorised operation amounting to assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional, while the latter is unintentional.'[106]

This position was reinforced in *Murray v McMurchy*[107] some sixteen years later. In that case the surgeon tied the plaintiff's fallopian tubes without her consent during a caesarian section operation on the ground that he had found tumours in her uterus. The defence of emergency was invoked and the same American cases were cited. Macfarlane J said, 'The point is whether such an emergency existed, whether it was *necessary* that the operation be done, not whether it was *convenient* to perform it.'[108] He held that while on the evidence the tumours *might* constitute a hazard to the plaintiff's health and that this was a matter of quantum, it did not justify a trespass. This indicates a gravitation towards the principle that, with the presence of a general consent, litigation is to take place in negligence, while without that general consent, litigation is to take place in assault, so increasing the liability of medical practitioners under the consent head.[109]

However, he held that she was entitled to neither punitive nor vindictive damages, but that she should be awarded what he called 'substantial damages'. This suggests that an action in negligence might have been available, but that was not pleaded. In the context of informed

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[105] 274.
[106] *Hershey v Peake* (1924), 115 Kan. 562 quoted in *Marshall v Curry* at 276.
[107] [1949] 2 DLR 442.
[108] 45. Emphasis in original.
[109] Cf. 1.2.2.1.

consent as outlined here, if the correct place for such actions is within the law of torts and the duty of care, then it must lie in the tort of negligence and it should be pleaded as such by the pursuer.

A quarter of a century after *Murray v McMurchy*, in *Kelly v Hazlett*[110] one can see that the drawing of a distinction between the two torts depends on the *intention* of the tortfeasor. In *Kelly* the defender had performed an osteotomy without the plaintiff's consent and both negligence and battery were pleaded. The grounds of the claim were considered under a separate head. It was not suggested that the osteotomy had been negligently performed and hence it was held that the resultant injury was 'unfortunate misadventure' rather than negligence.[111] Morden J summarised the law by saying,

> 'Broadly speaking, a battery is the intentional, unconsented to, touching of the person of the plaintiff by the defendant, while negligence (in the context of a case such as this) consists of the substandard execution of a duty of care by the doctor resulting in damage.'[112]

Morden J noted that the matter of informed consent could arise on both types of case.[113] Lack of proper information to the patient could vitiate consent and give rise to an action in battery, while failure to ensure that the patient is properly advised could amount to negligence.[114] Morden J said that in Canada, most cases of this sort had been determined as battery cases, but that in America the tendency had become to consider them as negligence matters. He held the difference to be an important one because it would have bearing on the onus of proof, on causation[115] and on the importance of medical evidence. Citing *Kenny v Lockwood* and *Halushka v University of Saskatchewan et al*,[116] he, too, held that such cases stem from the relationship between the parties, which gives rise to a duty of care. Where a duty of care is held to exist, the action is in negligence; it is the duty of care itself which moves the action from one in assault or battery to one in negligence. This in itself speaks to the intention

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[110] (1977) 75 DLR (3d) 536.
[111] At 555. This passage was to be quoted in *Reibl v Hughes* five years later.
[112] Ibid.
[113] This is curious in the light of the South African position, which considers the matter not as one of negligence but as one of consent. See 1.2.2.4.
[114] 556.
[115] See *Chatterton v Gerson* [1981] QB 432, 442C-443C. Cf. Chapter 4 on causation and Chapter 5 on expert evidence.

of the wrongdoer and the judicial policy which recognises that the wrongful omission is unintentional and therefore ought to be considered as negligence rather than as an assault.

By framing the issue relative to the surgeon's duty of care which arises from what the courts characterise as the nature of the doctor-patient relationship, courts make a policy decision to consign the matter to the tort of negligence. This is guided by the idea of restitutive damages and an orientation towards the patient. Establishing that a duty of care exists in the context of the need for information as the basis for valid consent,[117] and then considering Lord Nathan's *Medical Negligence*, Morden J went on to consider the extent of the physician's duty. This is the critical point in the inquiry because it concerned the *standard* of care. It is beyond dispute in the law of torts that proximity gives rise to a duty of care. The moot point is the scope of that duty and, in our context and the context of judicial policy,[118] whether it includes information on risks and alternatives.[119] For now, however, we are still considering the appropriate position of informed consent within the civil law.

Having established that a duty of care existed, Morden J found himself using elements of the law of torts to justify placing informed consent cases in the negligence pigeonhole. He had said that a duty existed and had described its extent. In order to fit more properly into the framework of the tort of negligence, it remained to establish that the duty was not fulfilled and that lack of due care resulted in injury. In fact Morden J said,

> 'It seems to me to strike a reasonable balance in the complex of interests, rights and duties subsisting in the patient-doctor relationship, as well as being consistent with basic concepts of the law of torts.'[120]

It is significant that he went on to exclude the tort of battery for policy reasons. He said that battery should be confined to 'intentional deviation from practice' and that most cases such as this are able to rely on the doctor's duty of care. Again, this is because battery is a matter of intention whereas negligence and the duty of care – particularly in the realm of omission

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[116] (1965) 53 DLR (2d) 436 cited in *Kelly v Hazlett* at 557-59.
[117] In *Halushka v University of Saskatchewan* et al at 442-3.
[118] Cf. 7.1.
[119] This will be more comprehensively discussed further on in this chapter (in 1.3.) and in Chapter 3 (particularly in 3.3. on Materiality).
[120] 558.

liability in the context of information disclosure – are matters of unintentional wrongs. It was this case which laid the groundwork on which *Hopp v Lepp*[121] and *Reibl v Hughes*[122] were able to build.

Although the court in *Hopp v Lepp* was able to be more assertive, it did not discuss this matter fully. There the action was argued on the basis of assault and battery as well as negligence resulting from the failure to disclose risks inherent in surgery. It differed from the cases discussed above in that it did not concern proxy or implied consent to an alternative procedure. Rather it was characterised as an informed consent case and as such is closer to the scenario sketched at the beginning of this chapter. Laskin CJC said that he did not need to consider the question whether the failure to disclose certain risks inherent in a medical procedure was 'consistent with an allegation of assault and battery.'[123] He noted that Morrow JA in the court *a quo* had considered the issue in both battery and negligence, before going on to analyse the latter by saying that 'the negligence here lay in unspoken words or in misleading words when there was a duty to speak and to be properly responsive.'[124] What is significant is the move by the Canadian judiciary towards defining the scope of the two torts more precisely while at the same time not committing itself fully.

The story so far is that it has been held, in judicial opinions, that the matter of informed consent falls within the duty of care because of the nature of the relationship between doctor and patient; in disclosure cases any negligence would be constituted by an omission to inform when there was a duty to do so. Informed consent matters fall within the genus *omission liability* and the problems associated with judicial policy to render certain omissions wrongful, persist.

Laskin CJC said that he preferred to leave the issue of the relationship between battery and negligence to another time. This time for the court, and in fact for Chief Justice Laskin, followed hard upon *Hopp v Lepp*. In the same year in *Reibl v Hughes* he pointed out that the

[121] (1980) 112 DLR (3d) 67.
[122] (1981) 114 DLR (3d) 1, 8-11.
[123] 73.

courts' tendency in situations of non- or insufficient disclosure[125] of inherent risks is to consider negligence rather than battery (except in circumstances of fraud or misrepresentation).[126] Considering the difference between the two torts, the court again cited with approval *Kenny v Hazlett* and *Halushka v University of Saskatchewan.*

When considering *Halushka*, the court in *Kenny* had suggested that they should consider first the nature of the risk and then look at where the action lies.[127] Laskin CJC then held that the distinction was both difficult to apply and 'incompatible with the elements of the cause of action in battery.'[128] This is because injury following alleged lack of informed consent is *unintentional.* In a policy-guided decision, Laskin CJC said,

> 'In my opinion, actions for battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.'[129]

Explaining this opinion, he went on to say that consent in such situations is not vitiated. Rather it is incomplete and 'arises as the breach of an anterior duty of care, comparable in legal obligation to the duty of care in carrying out the particular treatment to which the party has consented. It is not a test of the validity of the consent.'

This stance has remained unaltered to the present day. In the 1986 product liability case of *Buchan v Ortho Pharmaceutical (Canada) Ltd*[130] the court held that the rationale underlying such cases was the relationship of proximity and the responsibility and duty created by that relationship. By 1992 in *Lenis v deVilliers*[131] such actions had begun to be framed in negligence alone, following the landmark ruling in *Reibl v Hughes.*

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[124] Ibid.
[125] Disclosure requirements from Canadian case law are based on the prognosis of the patient, accessible alternatives and benefits, success and failure rates, known effects and risks, materiality, patient's means of inquiry and the physician's recommendation. Dickens BM (Ed) *Medicine and the Law.* 1993. New York University Press. 254-55.
[126] 11.
[127] 558-9, *Reibl v Hughes* at 9.
[128] 9.
[129] 10.
[130] (1986) 25 DLR (4th) 658, 666-7.
[131] 1992 Ont. CJ LEXIS 332.

The court in *Lenis v deVilliers* held that it was necessary to distinguish between cases in which the negligence consisted in failure to warn of material risks and cases in which the alleged negligence consisted in the carrying out of the medical procedure in question: for this the court cited *Karsanjii v Roque.*[132] Once it had been established that the appropriate form of action is in the tort of negligence, it is necessary to be even more specific as to what act, or in such cases what omission, amounts to negligence.[133]

Most recently the court in *Arndt v Smith*[134] did not need to consider the foundation of the action because it was pleaded *ab initio* in negligence. The questions before the court on the facts in issue were: was there a duty of care which would require the doctor to inform a pregnant woman of all material risks to an unborn foetus as a result of the mother's infection with chicken pox, did the doctor fail to discharge this duty of care and was there a causal link between that failure and the resultant injury? It is because of the arguments on the law of torts and the tort of negligence that the pleadings were able to be drawn up unreflectively in this way. If a plea is framed in negligence and a plaintiff succeeds in proving the requisite essential elements as required by the law of torts, so succeeding in the action, there can be no dispute about the proper place for the action in law.

1.2.2. THE PICTURE ELSEWHERE

1.2.2.1. ENGLAND

The action in *Bolam v Friern Hospital Management Committee*[135] was framed in negligence from the start and thereafter the inquiry of the court followed the path of that tort by considering whether the doctor was under a duty to warn. Early in his judgement, McNair J outlined what the court meant by negligence in the context of special skill saying that it was well established law that the requisite standard of competence was that of the ordinary man skilled in that particular art.[136] In this case it was found that he was not under a duty[137] to inform because the

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[132] (1989) 45 CCLT 172.
[133] See 1.2.2.1 and 1.2.2.4. on the use of different torts based on the same set of facts.
[134] [1995] 7 Med LR 108.
[135] [1957] 2 All ER 118.
[136] 121.

defendant had been acting in accordance with a respectable body of medical opinion which considered that in these circumstances there was no such duty.

McNair J referred with approval to *Hunter v Hanley*,[138] the benchmark Scottish case on this topic in which it was said that 'one man is clearly not negligent merely because his conclusion differs from that of other professional men...'.[139] Considering the civil liability of a medical practitioner, he considered *Halsbury's Laws of England* on negligence.[140] That these cases were framed in negligence arises from the pleadings. Thereafter the burden is on the plaintiff to prove the elements of an action in the tort or delict of negligence. Yet at times other forms of action have been considered.

Considering other personal injury torts, recent case law in England has considered assault and battery as well as negligence arising from the same act. The court in *Appleton and Others v Garret*[141] noted that it was not in dispute that a surgeon operating without consent commits an assault. The judgement referred to *Chatterton v Gerson and Another*[142] in which Bristow J summed up the position succinctly when he said,

> 'I think justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence.'[143]

The rationale behind this decision was dissected by Feng[144] in which he observes, as was noted earlier in this chapter,[145] that the torts of negligence and of trespass serve different functions.

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[137] See chapters 3 and 6 on the *Bolam* test.

[138] [1955] SLT 213.

[139] *Hunter v Hanley* at 217, *Bolam* at 121-122. The two tests appear different yet have a similar effect. See 2.2. and Chapter 5 generally.

[140] 22 *Halsbury's Laws* (2nd Ed.) 577-579, para. 829; 23 *Halsbury's Laws* (2nd Ed.) 318, 319, paras. 601-603.

[141] [1997] 8 Med LR 75. In that case none of the eight patients was given any information on which to base an informed consent and in the absence of consent the action lay in the tort of trespass to the person

[142] [1981] QB 432, [1981] 1 All ER 257, [1980] 3 WLR 1003, 1 BMLR 80, 31 January 1980.

[143] [1981] QB 432, 442C-443C. He went on to say, 'When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform, but that had the duty not been broken she would not have chosen to have the operation. Where the claim is based on trespass to the person once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented vitiation of the reality of her consent is irrelevant. In my judgement once the patient is informed in broad terms of the nature of the procedure which is intended and gives her consent, that consent is real and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass'

He observed that it had been the practice in America and Canada to consider the informed consent scenario as rendering consent ineffective and hence as giving rise to an action in battery. Feng goes on to argue that the *Sidaway* case, while remaining protective of members of the medical profession, actually expanded the liability of doctors by leaving the category of assault as it is and adding to the consent *genus* the requirement of information disclosure. This means that not only are doctors liable under assault for touching the patient with no consent at all, but they could be liable in negligence in instances of imperfect consent.

In declining the invitation to adopt the doctrine of informed consent, the court in *Sidaway* was, however, considering the doctrine in its 'original form.'[146] As such, the court was, according to Feng, considering a lack of full disclosure as giving rise to an action in assault because that very lack vitiates the general consent given. The court held, however, that consent is vitiated only if there is an omission to inform about the nature of the proposed treatment rather than an omission to inform of inherent risks in that treatment. In the latter case, the action would be in negligence because the information relates not to the nature of the treatment, but to the risks inherent in it, which is a collateral matter. In the case of *Chatterton*, the court held that the general consent provided a 'complete answer' to the trespass claim. The *caveat* to this, as has been held in all jurisdictions, is consent gained under circumstances of fraud or misrepresentation.[147] The difference between the two actions is one of the difference in the form of the information omitted. 'If the failure of information is to the nature of the treatment it relates to consent in trespass, and if it pertains to risks involved in treatment it is negligence.'[148] This is a distinction which has its roots in the criminal law.

Of importance in the doctor-patient relationship, is the need for fraud or misrepresentation to give rise to an action in assault. This is important in view of what was argued above on the nature of that relationship and the fact that the exchange between doctor and patient is not one which is associated with an assault case.[149] The doctor-patient

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[144] Tan Keng Feng. 'Failure of Medial Advice: Trespass or Negligence.' (1987) 7 *Legal Studies* 149.
[145] Cf. 1.2.
[146] Feng. Ibid. 151.
[147] See, for example, *Freeman v Home Office* [1983] 3 All ER 1036 and *Hills v Potter*[1983] 3 All ER716.
[148] Ibid. 153.
[149] Cf. 1.2.

relationship is one of trust and dependence and, because the assault action is more severe than the negligence action from a consequential point of view, courts have required additional elements to consign the facts to an action in trespass. These additional elements are fraud or misrepresentation, which imply some form of deceit and render the wrong that much more reprehensible. It is arguable, therefore, that courts are unable to shake the image of the medical practitioner as benevolent and caring, such that to convict one of trespass, some form of avarice needs to be proven.

It remains the case, however, that the category of trespass is available in those circumstances as well as in circumstances in which there was no consent at all to the procedure performed. From this a continuum can be constructed: the more probable the risk, the more likely it is that litigation may take place in trespass because with more probable risks, there is a greater chance that the information pertains to the nature of the treatment more than it does to 'collateral matters' such as inherent risks.[150] There is some support for this in Canada in *Kelly v Hazlett* in which Morden J said, 'The more probable the risk the more it could be said to be an integral feature of the nature and character of the operation.'[151]

It is perhaps for reasons such as this that the action would be in trespass, if the court were to hold that the information omitted was integral to the treatment. This is, therefore, a matter of numbers and of probability. The non-disclosure would have to be a serious one involving a high risk factor in order to give rise to an action in trespass. This is perhaps correct because the wrong is that much more serious and, logically, ought to give rise to a more serious legal action.

This rationale has had support through the case law. It is instructive, given the above arguments, to consider the case law chronologically. All cases involved low risks, which eventuated; the omissions could therefore be said to be less serious. None involved fraud or misrepresentation and all occurred within the doctor-patient relationship. Therefore, the above arguments on the context of that relationship mitigating against the use of battery hold good in

[150] This is an argument which is advanced by Feng. Ibid.
[151] (1976) 75 DLR (3d) 556, 559, as cited in Feng. Ibid. 157. footnote 28.

these instances. Perhaps most significantly, however, in all instances the omission was unintentional and, as such, it is entirely fitting that the action be one in negligence rather than assault.

In the sterilisation case of *T v T*[152] it was held that the surgeon operating without any consent at all commits battery against his patient[153] but that imperfect consent could amount to negligence. Much of this had been settled in *Hills v Potter.*[154] There Woolf J drew on *Chatterton v Gerson*[155] when he said, 'As to the claim for assault and battery, the plaintiff's undoubted consent to the operation which was in fact performed negatives any possibility of liability under this head.'[156]

The ground had been prepared well before *Sidaway*[157] - an action framed in negligence. The case law from around that time makes it clear that an action in negligence was, and continues to be, the dominant cause of action and that this negligence would necessarily involve a departure from general and approved medical practice.[158] Lord Scarman said,

> 'There is a further question of law as to the nature of the cause of action. Is it a cause of action in negligence, i.e. a breach of the duty of care, or is it based on a specific duty to inform the patient which arises not from any failure on the part of the doctor to exercise the due care and skill of his profession but directly from the patients right to know?'[159]

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[152] [1988] Fam. 52, [1988] 1 All ER 613.

[153] According to *Attorney General's Reference (No 6 of 1980)* [1981] QB 715 (CA), [1981] 2 All ER 1057, one cannot consent to battery (see also *R v Brown (Anthony)* [1993] 2 All ER 75, [1993] 2 WLR 556 (HL). This was upheld in *Collins v Wilcock* [1984] 1 WLR 1172, [1984] 3 All ER 374 and by the European Court of Human Rights. Here, however, we are considering ill-informed consent rather than general non-consent, although the categories do, at times, overlap.

[154] [1983] 3 All ER 716.

[155] [1981] 1 All ER 257, [1981] QB 432.

[156] [1983] 3 All ER 716, 728e-f.

[157] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 HL, [1984] 2 WLR 778; [1984] AC 871.

[158] *Clark v MacLennan* [1983] 1 All ER 416.

[159] [1984] AC 871, 877. This was part of Lord Scarman's dissenting judgement, which will receive fuller treatment in Chapter 3. On rights and a critique of Lord Scarman's approach, see 5.3.1.1. Here Lord Scarman's argument is interesting insofar as Lord Scarman was framing the question as a rhetorical one which he went on to answer in favour of the basis of the doctor's duty flowing from the patient's right to know. The important point here is that the action concerns a relationship *inter partes* which gives rise to certain duties. Whether these duties exist (as well their extent) depends on the jurisdiction. This, too, will be more fully considered in the next chapter and particularly in 6.3.1.1.

Having considered *Chatterton v Gerson* and *Hills v Potter*, Lord Scarman concurred on this issue by saying that 'it would be deplorable to base the law in medical cases of this kind on the torts of assault and battery.'[160]

Basing this opinion on case law tends, however, to obscure the extent to which this decision is guided by the policy of protecting the medical practitioner by ensuring that the burden of proof lies with the plaintiff.[161] Later in his judgement Lord Scarman said that if in English law there is a duty to warn of risk, then failure so to do would constitute a breach of the duty of care and would be actionable in negligence. He went on to argue that in applying the *Bolam* principle, the court would conclude that there was no such duty recognised and hence no case to answer in the law of negligence. However, we see later that he said,

> 'I conclude, therefore, there is room in our law for a legal duty to warn of the risks inherent in the treatment proposed, and that, if such a duty be held to exist, its proper place is as an aspect of the duty of care owed by the doctor to his patient.'[162]

According to Lord Diplock in the same case, '[t]he relevant form of action has been based in negligence, i.e. in *assumpsit*, alone.'[163] It is interesting in terms of the contractual context in which this is viewed in South African law[164] that although Lord Diplock stated unequivocally that the relevant cause of action lay in the tort of negligence, his use of the term *assumpsit* indicates that, historically at least, remedy lay in restitution which is different from either contract or tort. This would thus appear to be a curious comment considering that *assumpsit* had its origins in the law of torts, yet from the seventeenth century has been used as a contractual remedy.[165] For present purposes what is interesting about the *Writ of Assumpsit* is that the obligation of a party is itself founded on consent.[166] *Assumpsit* is also consistent with the principle that the purpose of the law of torts is to place the plaintiff in the position in which he would have been had the wrong not been done and can now be seen as analogous to

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[160] [1984] AC 871, 883.
[161] In this chapter, see 1.4. on the burden of proof and 16. on policy.
[162] [1984] AC 871, 886C.
[163] [1985] 1 All ER 871, 894C.
[164] Discussed in 1.2.2.4. below.
[165] In the nineteenth century common law the forms of action were split into contract and tort actions. See *Halsbury's Laws of England*, Vol.9 para 636.
[166] See Halsbury's Laws of England, Vol.9 para 632.

restitution in equity or in law; hence a subjective standard is applicable.[167] The analogy is seen to run deeper still when one considers the equity principle as operative in fiduciary relationships.[168]

The entrenchment of this position became clear in *Thake v Maurice*.[169] In that case it was averred that the defendant had contracted to render the plaintiff totally sterile through a vasectomy operation. It was held that the defendant carried out the operation in accordance with his duty of reasonable skill and care. Neill LJ held that both litigating parties expected that the operation would result in sterility but that such an expectation did not extend to a guarantee of sterility. He held,

> 'Furthermore, I do not consider that a reasonable person would have expected a reasonable medical man to be intending to give a guarantee. Medicine, though a highly skilled profession, is not, and is not generally regarded as being, an exact science. The reasonable man would have expected the defendant to exercise all the proper skill and care of a surgeon in that speciality; he would not in my view have expected the defendant to give a guarantee of 100% success.'[170]

The claim had been pleaded in both contract and in tort. Because the claim in contract failed, the matter was litigated in negligence *simpliciter*[171] rather than contractual negligence. This case was later supported by *Eyre v Measday*.[172] However, patients treated under the National

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[167] On the subjective standard and slippery slope arguments, see 5.4.4., 6.3. & 6.4.

[168] See *Halsbury's Laws of England* Vol. 9, para. 631 and the Introduction to this thesis on the fiduciary nature of the doctor-patient relationship.

[169] [1986] 1 All ER 497, 510d-j.

[170] 510g-h.

[171] What is meant by *simpliciter*, in the context of this thesis, is negligence based on performance of medical procedures or in diagnosis rather than negligence based on information disclosure.

[172] In *Eyre v Measday* [1986] 1 All ER 488, Slade LJ considered actions in contract and agreed with the court in *Thake v Maurice*. He narrowed it down to two questions: was this a contract by which the defender contracted to render the plaintiff totally sterile and, if not, did the contract contain an express or implied warranty to this effect? Considering that the contract was constituted by both the signed consent form and the consultation between plaintiff and defender he said, 'It is also common ground, I think, that, in order to ascertain what was the nature and what were the terms of the contract, this court has to apply an objective rather than a subjective test [which] depends on what the court objectively considers that the words used by the respective parties must be reasonably taken to have meant.' (492j-493a) Slade LJ found that the contract was one to perform a laparoscopic sterilisation. On this clause the defender had performed. However, the nature of the procedure was such that no such guarantee of success could possibly be given. Even though Slade LJ held that the contract did include an implied warranty of that nature, 'that inference did not entitle the plaintiff to succeed' (495) because, objectively assessed, no surgeon acting with reasonable care could give such a guarantee.

Health Service in the United Kingdom will not have a contract with the Health Authority and hence will not be able to sue in contract.

More recent case law has supported this now-settled position. *McAllister v Lewisham*[173] was an action brought in negligence on the basis of the doctor's failure in his duty of information. This duty was tested against a professional standard. A similar situation was presented to the court in *Smith v Tunbridge Wells Health Authority.*[174] There, too, the elements of the claim were those of a claim based on the tort of negligence. Similarly, *Newell and Newell v Goldenberg*[175] and *Lybert v Warrington Health Authority*[176] were informed consent cases framed in the tort of negligence which required the plaintiff to prove that on the basis of the standard of the reasonable practitioner there existed a duty to provide the desired information on which consent was based, that the defender failed to fulfil this duty and that this negligent failure caused or materially contributed to the injury suffered by the plaintiff.

1.2.2.2. SCOTLAND

The test in *Hunter v Hanley* has been discussed in the English context because it is one which was taken up in order to formulate the *Bolam* test. On the *quid juris* question, the position in Scotland is similar to that in England. In *Jones v Lanarkshire Health Board*[177] the difference between contract and negligence was considered crucial when it comes to informed consent. Lord Prosser said,

> '[he did] ... not consider this one of those cases where one is merely altering the legal label on what is essentially the same subject matter. A case can be wholly new in law, even upon identical facts, and in my view the facts of the present case have to be looked at in a wholly new light given the change to a case founded in delict.'

There can be little doubt that the action lies in delict. This was the basis for the actions in *Moyes v Lothian Health Board*[178] and *Goorkani v Tayside Health Board.*[179] But as this thesis

[173] [1994] 5 Med LR 343.
[174] [1994] 5 Med LR 334.
[175] [1995] 6 Med LR 371.
[176] [1996] 7 Med LR 71.
[177] 1990 SLT 19.
[178] [1990] 1 Med LR 463.

will go on to argue in the light of the South African law, within the law of delict an action might lie in respect of consent and a wrongful omission to warn, rather than in negligence.[180]

1.2.2.3. AUSTRALIA

The English and Australian cases based on limitation of actions make it clear that negligence based on a lack of informed consent is distinct from negligence based on professional performance or technical skill.[181] Although not a case of alleged medical negligence, *Dornan v J W Ellis & Co. Ltd*[182] is a basis from which to argue that introducing further particulars of claim to the original writ does not constitute a fresh cause of action. Rather, the new particulars 'merely [invite] a different approach to the same facts.'[183] It is a question of the court determining whether an amendment is a new cause of action or a new particular.[184]

The *Dornan* case was cited in Australia in *Re Katherine Mary Golski* as a basis from which to argue that a new cause in law can be pleaded using the same set of facts. There Kelly J, citing Windeyer J in *Anchor Products Limited v Hedges*,[185] said,

> 'The cause of action was negligence. The particulars of the acts or omissions which were relied on as constituting the negligence alleged could, at the discretion of the trial judge, be expanded by amendment to meet matters that emerged in the course of the trial.'

Still citing Windeyer J, he held that the function of these particulars in an action for negligence was 'not to define the cause of action, which is negligence, but to show what acts or omissions will be put forward as constituting it.'[186]

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[179] [1991] 3 Med LR 33.
[180] Cf. Chapters 3 and 6.
[181] This crops up in such cases because of statutory time bars on civil tort actions which cause plaintiffs to litigate for the inclusion of new causes of action.
[182] [1962] AC 583.
[183] Ibid. 583.
[184] 591. Cf. the Scottish position in *Jones v Lanarkshire Health Board* 1990 SLT 19, 23 as discussed in 1.2.2.1.
[185] (1966) 115 CLR 493, 499.
[186] Kelly J went on to hold, 'In my opinion, a plaintiff should not be allowed to introduce new claims by amendment which in substance amount to the bringing of a new action for claims already barred by statute. However, where the proposed amendments do not change the cause of action but do no more than particularize the facts by which the respondent proposes to sustain it even though the facts sought to be brought forward under the amendment are quite different from those originally alleged, amendment will be allowed.'

As long as the plaintiff relies on the same set of factual circumstances, that plaintiff will be given leave to amend their particulars of claim. This can include situations where, for example, a plaintiff in an action for negligent treatment may want to include a claim for negligence flowing from a lack of fully informed consent.

The first Australian 'informed consent' case with which we are concerned is *F v R*[187] which showed a move away from a professional standard. The case was framed in negligence and it is clear from the above discussion and the Australian case law that this is the correct position there too. King CJ said,

> 'The ultimate question, however, is not whether the defender's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law.'[188]

This is wording clearly taken from the tort of negligence; but what of other torts?

Vaughan v Bailey[189] was an interrogatory and discovery hearing on an allegation that the defender failed to obtain valid and properly informed consent to the treatments used. In the alternative it was alleged that the consent given was in effect null. The interest of the case lies in the distinction between negligence and battery because if the court found that the consent was absent, the action would lie in battery, whereas if they found it to be merely inadequate, the action would lie in negligence. In the event the court considered the matter in negligence, as did the court in *Gover v State of South Australia.*[190]

The judgement in *Re Katherine Mary Golski*[191] touched on the trespass action by drawing on *Sidaway,* noting that there Lord Scarman[192] had said that an action for that tort was not available because Mrs Sidaway had consented. The court in *Gover* agreed that any form of

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[187] (1983) 33 SASR 189.
[188] 194.
[189] CLD 17011 of 1980, in the Supreme Court of New South Wales, Common Law Division, 1984 NSW, LEXIS 2418; BC8400252, 27 September, 1984.
[190] (1985) 39 SASR 343.
[191] 1987, Lexis. Federal Court of Australia, Australian Capital Territory District, 16 April 1987.

consent elides the possibility of an action in assault but that imperfect consent could found an action in negligence. Kelly J insisted that damage was the gist of an action in negligence. In law, the type of action to be brought follows the particulars of the claim. A potential plaintiff would proceed from the existence of damage and go on to consider the existence of other elements such as duty of care, its breach and causation; at which point it will be apparent to the plaintiff where the action might lie.

The court in *Ellis v Wallsend District Hospital*[193] argued the matter of informed consent in negligence. At an instructive point in the judgement, Kirby J held that he need not consider the claim in assault or in contract[194] because as regards the former there was consent, though imperfect; as regards the latter, the matter was not argued.

Considering the tort of assault, the court in *Marion's Case*[195] agreed that 'the law treats as unlawful, both criminally and civilly, conduct which constitutes an assault on or a trespass to the person' and went on to note the exceptions to the defence of consent.[196] The court then spoke specifically of medical treatment saying that, '[t]he factor necessary to render such treatment lawful when it would otherwise be an assault is, therefore, consent.'[197]

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[192] AC, 822.

[193] [1990] 2 Med LR 103, (1989) 17 NSWLR 552.

[194] 113.

[195] *Secretary, Department of Health and Community Services, J.W.B. and S.M.B.* (Marion's Case) F.C. 92/010, High Court of Australia, (1992) 175 CLR 218.

[196] The court drew on various examples, which are worth citing here for the sake of completeness. It noted that a person in the Northern Territory cannot render a killing lawful by consenting to be killed and that at common law a comparable qualification exists with respect to assault. (Citing *A-G Reference (No.6 of 1980)* [1981] QB 715 which had held that those entering into a consensual fight were guilty of assault if they intended to inflict bodily harm, as well as *The Queen v Coney* (1882) 8 QBD 534; *The King v Donovan* (1934) 2 KB 498). The rationale for this exception rests in the idea that some harms involve public rather than personal interests and that the absence of consent is irrelevant in a lawful arrest, or in circumstances which amount to self-defence. Consider, in this light, *R. v Brown* [1993] 2 All ER 75 (HL) concerning private sexual practices. The case was taken to the European Court of Human Rights, which decided on the ground that the acts were public (because there was more than two men participating) that Britain was correct in prosecuting three men for causing injuries during sadomasochistic sexual practices.

[197] Here the court cited *In re F* [1990] 2 AC 1, per Lord Goff of Chiverley at 73-74 and *Wilson v Pringle* [1987] QB 237, 252.

As we have seen, and according to *Daniels v Burfield*, the negligence action is based on things said and not said[198] which are argued to have materially contributed to some harm to the plaintiff. That case supported *F v R* in the framing of the action. Similarly, *Young v Northern Territory*[199] started out as a negligence claim, yet in the alternative the court was obliged to consider breach of contract. Again, this depended on the manner in which the pursuer brought the claim. The claimant alleged that the defenders were negligent and/or in breach of their contract in that they failed to properly advise the plaintiff and to inform themselves of the plaintiff's past history. The case was adjudicated in negligence and did not involve any contractual inquiry. This is an understandable development in a case in which allegations are made in the alternative: the court held that it was unnecessary to consider breach of contract in the light of their findings for the defender on the basis of negligence.

Rogers v Whitaker[200] remains the leading case in Australia and has recently been supported by the decision in *Chappel v Hart.*[201] Proceedings were commenced for negligence, because by 1993 it had been established where the action lay. Consequently the case is important mainly for its analysis and testing of the standard of care and the alleged breach of that duty by the defender. *Rogers v Whitaker*, like the latter English and Canadian cases discussed, was able to consider the claim within the parameters of the tort of negligence. The same position faced the court in *Hart v Chappel*[202] in the Supreme Court of New South Wales and on appeal in the High Court of Australia. Hayne J., dissenting, argued that Mrs Hart failed on causation in her negligence action, but because she had pleaded her case in both negligence and contract, he argued that her claim in the latter succeeded and entitled her to nominal damages, but no more. This indicates another difference between the two actions; the measure of damages is that much greater if the claim is in negligence. (For example, had Mrs Donoghue pleaded her case in contract, she would have received only the value of a replacement bottle of ginger beer in damages.)

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[198] *Daniels v Burfield* (1991) AUST SASC 1769, 1771 et seq.
[199] *Jeanette Evelyn Young v Northern Territory of Australia, Albery Raymond Anderson and Lorraine Evans*, No. 46/1987, in the Supreme Court of the Northern Territory of Australia, 15-28 October 1991, Judgement 22 May 1992, Lexis.
[200] [1993] 4 Med LR 79.
[201] [1998] HCA 55 (2 September 1998, unreported as yet) which upheld the ruling in *Hart v Chappel* [1994] 5 Med LR 365 and found the test in *Rogers v Whitaker* to be a correct formulation of Australian law.
[202] [1994] 5 Med LR 365.

The court in *Breen v Williams*[203] discussed the patient's rights (as submitted by counsel for the plaintiff), as based variously on contract, property and fiduciary duty. With regard to contractual obligations giving rise to an action, Brennan CJ said,

> 'In the absence of special contract between a doctor and a patient, the doctor undertakes by the contract between them to advise and treat the patient with reasonable skill and care. The consideration for the undertaking may be either a payment, or promise of payment, of reward or submission by the patient, or an undertaking by the patient to submit, to the treatment proposed. A duty, similar to the duty binding on the doctor by contract, is imposed on the doctor by the law of torts. The advice and treatment required to fulfil either duty depends on the history and condition of the patient, the facilities available and all the other circumstances of the case.'

This suggests that the Australian position is unusual. Indeed, contrary to the Canadian position, Brennan CJ held that an action may also lie in contract.[204] The learned judge did, however, hold under the same point that,

> 'A similar duty may be imposed on the doctor by the law of torts but, in particular situations, for example, some emergency treatments, the relationship between doctor and patient may not give rise to a duty that extends so far. It is not necessary now to consider that problem.'

The case of the plaintiff, however, rested on the serving of her 'best interests' as an implied term of the contract. On this the judge had the following to say:

> 'There are good reasons why Australian courts do not imply a "best interests" term, as a matter of law, into all doctor-patient contractual relationships. First, "[w]here a term is implied into a contract it will usually embody a contractual promise and therefore create a legal duty."[205] Such a duty would be inconsistent with the existing contractual and tortious duty to exercise reasonable care and skill in the provision of professional advice and treatment. The existence of a tortious duty of care militates against "the implication of ... a general contractual duty of care",[206] particularly where "the incidents of an independent general contractual duty of care would differ from those of an independent

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[203] [1995] Med LR 385.

[204] He said, 'information with respect to a patient's history, condition or treatment obtained by a doctor in the course or for the purpose of giving advice or treatment to the patient must be disclosed by the doctor to the patient or the patient's nominee on request when (1) refusal to make the disclosure requested might prejudice the general health of the patient, (2) the request for disclosure is reasonable having regard to all the circumstances and (3) reasonable reward for the service of disclosure is tendered or assured.'

[205] Here citing Carter and Harland, *Contract Law in Australia*, 3rd ed. (1996). 204.

[206] Here citing *Hawkins* (1988) 164 CLR 539, 582-583.

tortious duty".[207] Second, the meaning and application of an implied term must be reasonably certain.'[208]

The Australian picture which emerges is substantially the same as that in both Canada and England: the relevant cause of action lies in the tort of negligence unless there was no consent to the procedure, and that the law of contract is not useful because of a clash with the law of torts. It is clear, however, that the issues all boil down to a relationship between the litigating parties which is sufficiently close to found a duty of care, the breach of which is alleged to have caused the plaintiff some harm, but that this duty is forged in a contractual *context*.

1.2.2.4. SOUTH AFRICA

The position in South Africa is similar to one already sketched, with some key differences already alluded to. *Esterhuizen v Administrator, Transvaal*[209] was an action brought on the ground of the delict of assault. The court pointed out that English law, which deals with assault under the broad heading of trespass to the person, was dissimilar to South African law in which the action is dealt with under the *actio iniuriarum*. In *Esterhuizen* an employee of the defendant hospital authority treated the plaintiff with powerful X-rays without her consent knowing that they could cause disfigurement and possible necrosis.

In South African law, as in Scots law, assault constitutes an *iniuria*. The court pointed out that this means that, 'the act of intentionally and unlawfully applying force to the person of another' constitutes an assault[210] and hence there is no onus on the plaintiff to prove that the act was committed without consent.

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[207] *Hawkins* (1988) 164 CLR 539, 584.
[208] Citing, by way of example, *Luxor (Eastbourne) Ltd v Cooper* [1941] AC 108, and *Codelfa Construction Pty Ltd v State Rail Authority of NSW* (1982) 149 CLR 337.
[209] 1957 (3) SA 710 (T).
[210] 711.

Consent constitutes a defence to an assault charge,[211] which means that the onus is on the defendant to prove consent on a balance of probabilities, so rebutting the *prima facie* case of the plaintiff. *Prima facie*, there cannot be consent to surgery unless the risks are explained and speaking of consent in that context presumes the possibility of the *volenti* defence. Bekker J found that even if the plaintiff had borne the onus of proving that she had not consented, that onus had been discharged. He held that no matter how laudable the motives of the practitioner, if he administers inherently dangerous treatment to the patient without that patient's consent, 'he does so at his own peril.'[212] Accordingly, judgement was given in favour of the plaintiff. The position with regard to an absence of consent would appear clear. The position is less stable in respect of allegedly ill-informed or inadequate consent.

From early this century actions involving the consent of the plaintiff-patient have been framed in negligence. As early as 1925, *Lymbery v Jefferies*[213] was framed in negligence and so obliged the court to consider the matter in terms of the essentials of that action. The case remains one of the earliest in which the consent of the plaintiff was a consideration because the primary allegations were that she had not been informed that she could become sterile following X-ray treatment; nor had she been informed that the treatment was dangerous.[214] Because the action was framed in negligence, the court was obliged first to consider whether in the circumstances a duty of information existed at all. But these were early days yet for informed consent. It was held that the facts could not support the allegation that the plaintiff had not been informed about the possibility of sterility and that, with regard to informing the plaintiff that the treatment was dangerous, there was no such duty on the defender in the circumstances.

The consideration which arose in *Lymbery v Jefferies* in 1925 arose again half a century later in the Cape Provincial Division in *Richter and Another v Estate Hammann.*[215] In an amendment to the particulars of claim it was alleged that the defendant was negligent in not

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[211] *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T)
[212] 721.
[213] 1925 AD 236.
[214] Other allegations were that the defender was negligent in sending the plaintiff to an unqualified radiologist and that following her complaints concerning the treatment, the defender negligently told her to continue with it.
[215] 1976 (3) SA 226.

warning the plaintiff of a remote possibility of complications, as well as in the administration of the treatment which he had advised. The court held that under these circumstances the defender was not under such a duty.

Similarly, *Blyth v van den Heever*[216] was an action brought in negligence on the basis of a failure to diagnose and take proper action in respect of post operative sepsis and ischemia[217] and, had the diagnosis been correctly made, damage would not have been suffered. Of note here is that the case had to do with liability for an omission and that the same test was put forward for both diagnosis and treatment.[218]

The court in *Collins v Administrator, Transvaal*[219] held that in a delictual action framed in negligence, damages were to be compensatory rather than punitive; this distinguished civil from criminal law. Remaining on the topic of the *context* of informed consent, the relationship between contract and delict is one which emerges as an interesting facet of the South African law. This is especially so considering Lord Templeman's comment in *Sidaway*[220] that the doctor, 'obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient'. In this way he positioned the relationship between the parties in a contractual context in England.[221]

As early as 1924 in *Van Wyk v Lewis*,[222] Innes CJ held that the action was based in negligence rather than contract, yet he argued that 'the line of division where negligence is alleged is not always easy to draw; for negligence underlies the field of both contract and tort.' This is particularly interesting when one takes into account the contractual context considered in *Castell v De Greef*[223] seven decades later.

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[216] 1980 (1) SA 192.
[217] Following a fracture or the right radius and ulna.
[218] 3.2. will return to the matter of a different test for negligence *simpliciter* from that applicable to information disclosure.
[219] 1995 (4) SA 73. This was not a consent case.
[220] (1985) AC 871, 904.
[221] And provided a background to the Australian case of *Breen v Williams* discussed earlier.
[222] 1924 AD 438, 443-444.

In the years between the two cases, the courts considered the matter in *Correira v Berwind*[224] in which it was argued by the defendant surgeon that the plaintiff's claim, based on contract, had prescribed. There the court held that the legal relationship between doctor and patient can give rise to both contractual and delictual liabilities. The court also found that delictual liabilities exist independent of any contractual provisions. Mfalila J quoted Lord Nathan's classic text, *Medical Negligence*:[225]

> 'In the great majority of cases the duty owed by a medical man or a medical institution towards the patient is the same whether there exists a contract between them or not.'[226]

'The fact that the relationship between doctor and patient is *usually* one of contract'[227] has no bearing on the existence of delictual liability; but it remains an interesting context in which to consider the non-litigious interaction between the parties. This is interesting because of the academic argument that a breach of contract should properly be classified as a form of delict.[228] Mfalila J held that both actions can proceed from the same set of facts.

It remains a question of determining the wrong from which the damage arose in order to determine the cause of action to be instituted.[229] The facts of *Van Wyk v Lewis* satisfied the requirements of both a contractual and a delictual action because delictual liability exists independent of contract. However, in *Lillicrap, Wassenaar & Partners v Pilkington Brothers (SA)(Pty) Ltd*,[230] Grosskopf AJA brought policy into the equation by saying,

> ' ... I do not consider that policy considerations require that delictual liability be imposed for negligent breach of contract of professional employment of the sort with which we are here concerned.'

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[223] 1994 (4) SA 408.
[224] 1985 (4) SA 60.
[225] 1957, 15.
[226] 63.
[227] Ibid. 63. Emphasis in original.
[228] See *Lillicrap, Wassenaar & Partners v Pilkington Brothers* (SA)(Pty) Ltd 1985 (1) SA 475 (A), 496.
[229] *Correira v Berwind* 1985 (4) SA 60, 65.
[230] 1985 (1) SA 475, 501G-H.

It would appear that the 'existence of a concurrent contractual liability is no bar to an action in delict, provided that the requirements of delictual liability are also satisfied.'[231]

As in *Sidaway*, the court in *Castell v De Greef*[232] placed the relationship - as opposed to the legal action - between doctor and patient in the contractual *context*.[233] We will see in the next chapter that this case marked the introduction to South African law of a patient-oriented approach to the duty of care. *Castell* was an action framed in negligence. Nonetheless, Ackerman J, drawing from *Rogers v Whitaker*'s critique of the American judiciary's use of terminology such as 'the patient's right of self-determination' and 'informed consent' said,

> 'In any event, [the Australian criticism] does not seem to me to be appropriate in South African law, where the issue is treated not as one of negligence, arising from the breach of a duty of care, but as one of consent to the injury involved and the voluntary assumption of an unintended risk. In the South African context the doctor's duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its *sequelae*.'[234]

Ackerman J pointed out that the criticism in *Rogers v Whitaker* of the expression 'informed consent' was on the basis that '... consent is relevant to actions framed in trespass, rather than negligence .'[235] Mason CJ in *Rogers v Whitaker* went on to endorse the Common Law position by framing the issue in negligence. Ackerman J then reiterated that South African law takes a different position because of the availability of the *volenti* defence; he went on to hold that while the position formulated in *Rogers v Whitaker* was a correct one, it ought to be 'adapted to the needs of South African jurisprudence.'[236]

This puts a new complexion on the issue insofar as it may be related to the *iniuria* of assault. The court argued that the defence of *volenti non fit iniuria* was available and that this removed the case from the confines of the delict of negligence. With the operation of the

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[231] Boberg PQR. *The Law of Delict*. 1984. Juta. Johannesburg. Opening chapter on 'Nature and Basis of Delictual Liability'. p1.
[232] 1994 (4) SA 408.
[233] This was to have a bearing on causation. See Ch. 4, specifically on the use of the defence of *volenti non fit iniuria* in 4.7.
[234] 425D-F, drawing on *Van Wyk v Lewis* and *Correira v Berwind*.
[235] 425J-426A.
[236] 426D.

volenti defence, consent is kept broadly within those confines,[237] yet the element of wrongfulness is established by the facts of the case. In effect, the court was judging the facts relative to *culpa* rather than more narrowly and in terms of negligence. Wrongfulness, in those terms, could be constituted by negligence, assault or, as Ackerman J held, by failure to procure an informed consent as assessed relative to the defence of *volenti non fit iniuria.*

Friedman v Glicksman[238] was a wrongful birth and wrongful life action, which discussed the delictual claim of a mother for the wrongful birth of her daughter. The court established that the nature of the doctor-patient relationship means that the harm to the plaintiff was foreseeable and that this constituted the necessary fault element in the law of delict. Considering causation, the court held,

> 'The claim is based upon the fact that, but for the defender's negligent advice [that the child was not going to be born abnormal or disabled], the plaintiff would have had her pregnancy terminated. Thus the defender is responsible and caused the child, with her disabilities, to be born.'[239]

On the face of things *Friedman* could be seen as having gone against the ruling in *Castell v DeGreef*, but *volenti* was not pleaded in defence. It would seem, then, that a case will be considered within the scope of the law of negligence, unless *volenti* is pleaded. Be that as it may, the most up to date decision on the issue of informed consent remains *Castell v DeGreef.*

1.2.3. NOT SO DISTINCT A TORT OF NEGLIGENCE

The picture which is emerging is a 'collage of negligence', with different jurisdictions using negligence tests in different ways. English and Scottish courts use the same test to establish whether there has been negligence (the test in *Hunter v Hanley*) or to exculpate from negligence (the *Bolam* test) in respect of treatment and in respect of the duty of information. Courts in Australia and Canada, on the other hand, separate the test for the duty of care in negligence

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[237] because any judgement will be expressed in negligence terms
[238] 1996 (1) SA 1135.
[239] 1139B-C.

simpliciter from that for negligence in respect of the duty of information.[240] The policy of the South African Judiciary was to employ different tests by removing consent matters from negligence and to test them simply as wrongfulness cases. This means that while these matters are litigated broadly in negligence, the principles and tests associated with that tort are not uniformly employed.

1.3. THE COURT AS ARBITER

It is important that the court is the final arbiter of the standard of care and the matter of its breach. This is because any legal test which empowered any one particular party would be open to abuse. It is true to say that different parties are given differently weighted power in any legal test, but if the court declares itself to be the final arbiter on the admissibility and weight of evidence, this can lead to a fairer result. It is because of this principle, for example, that the *Bolam* test could be used to the effect that it was used in the *Bolitho* case.[241] In that case, the court had to determine the hypothetical causation using the *Bolam* test. In that way, the House of Lords was making use of judicial tests to determine the outcome of case, rather than merely accepting at face value the views of experts or defendant.

It had been held in *Sidaway* the courts would not defer to the views of experts but will assess their evidence according to the applicable judicial tests. Lord Browne-Wilkinson had outlined the *Bolam* test and referred to its use in *Maynard v West Midlands AHA*[242] and *Wilsher v Essex AHA* and went on to hold, that 'the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis.'[243] This is more important in the context of information disclosure than it is in the context of negligence *simpliciter* because there is more room for disagreement among professionals in respect of what they, in their opinion, would have told a particular patient, than there is room for disagreement

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[240] Cf. 3.2.

[241] [1997] 4 All ER 771. This case will be discussed *inter alia* in 4.3. It is particularly relevant to the issue of the court as arbiter over the matter and as asserting its own authority over the case rather than deferring to the opinions of expert witnesses.

[242] See also the judgement of Donaldson MR in *Sidaway* (CA) (WLR, 792) in which his Lordship had considered the need for a medical practice to be 'rightly' adopted.

[243] [1997] 4 All ER 771, 778*f*.

on the appropriate treatment or diagnosis. This is the case because the requisite standard of information disclosure can depend on the patient's desire for knowledge, while negligence *simpliciter* has more to do with medical science.[244]

This method of assessment of expert evidence is arguably a control device over evidence which is provided by medical experts and the medical profession generally. This is a further instance of judicial policy. The Court declares itself to be the final arbiter of the professional standard, of what constitutes reasonableness and of the acceptance of expert evidence. This is because ideal practice should, as the court put it, be 'rightly' adopted by the profession.[245] This attitude reflects a difference from the time last century when cases were heard by a jury.[246]

Entrenching this in *Roe v Minister of Health*,[247] Lord Denning MR indicated that there are some practices of the medical profession that the court might hold to be negligent. Similarly Wessels JA, in demonstrating the similarity of South African to English law while using American cases in *Van Wyk v Lewis*, considered reasonableness to be a decision for the court. He said,

> 'The Court can only refuse to admit such a universal practice if *in its opinion* it is so unreasonable and so dangerous that it would be contrary to public policy to admit it. In determining whether such a practice is reasonable or not the Court must take into consideration the advance in medical science and modern practice.' [248]

What constitutes reasonableness, universal practice, modern practice and public policy are all subject to the opinion of the court. This means that no matter what the court's test for either causation or for whether the duty of care exists and was breached in the circumstances, the

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[244] Cf. Chapter 5.
[245] See Donaldson MR in *Sidaway* (WLR, 792) and Hirst J in *Hills v Potter* [1983] 3 All ER 716, 728. See also Norrie K McK 'Standards of Disclosure' 1984 SLT 237. Cf. Chapter 5 on the expert. See also comment by Margaret Puxon QC following *De Freitas v O'Brien* [1995] 6 Med LR 108, 116.
[246] *Lanphier v Phipos* (1830) 8 Car & P 475; *Rich v Pierpont* (1862) 3 F & F 35.
[247] [1954] 2 All ER 131.
[248] 1924 AD 438, 460. Own emphasis.

court itself remains the arbiter; rather like making only those rules which one can oneself keep.[249]

There is an argument that it is paternalistic of the law to involve itself in the way it does with medicine - that is by reserving the right to decide. In *Sidaway*, for example, the House of Lords adopted a paternalistic and medically oriented approach and aligned informed consent with professional duty; yet it did not leave the issue in the hands of the medical profession alone.[250] That case concerned a patient who was not told of a one per cent chance that spinal damage might result from an operation on her neck. The House of Lords confirmed that the *Bolam* test applies to disclosure of inherent risks, yet ruled that medical opinion was not decisive.[251]

More recently and more to the point, Chief Justice Mason in *Rogers v Whitaker* quoted, with approval, Laskin CJC in *Reibl v Hughes* on the supremacy of the law.[252] He also quoted King CJ in *F v R* as having said,

> '"The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community."'[253]

Following this there can be little dispute over the court's assertion of its own competence; a competence which is self-valedictory and which will serve as an insurance policy against being unable to make policy-guided decisions while interrogating other facets of the legal inquiry into informed consent and medical negligence.

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[249] In *Hucks v Cole* ((1968) *Times*, 9 May; [1993] 4 Med LR 393, 379, Col. 2), Lord Justice Sachs said, 'When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risks, the courts must anxiously examine that lacuna - particularly if the risks can be easily and inexpensively avoided.'

[250] *Bolam*, it should be noted, was only a decision of first instance and what has become the *Bolam* test was part of the summing up to a lay jury. Goldrein considers it too archaic to be applicable in tort cases four decades after the decision: Iain S Goldrein 'Bolam - Problems Arising Out of "Ancestor" Worship' (1994) 144 *New Law Journal* 1237 (September 16, 1994).

[251] Cf., 3.2.1.

[252] In which Chief Justice Mason had said, 'To allow expert medical evidence to determine what risks are material and, hence, should be disclosed ... is to hand over to the medical profession the entire scope of the duty of disclosure, including the question of whether there has been a breach of that duty.'

[253] *Rogers v Whitaker* [1993] 4 Med LR 79, 82, Col. ii.

1.4. THE BURDEN OF PROOF[254]

By adhering to the policy considered earlier in this chapter to remain within the tort of negligence, the burden of proof remains on the plaintiff, so protecting the practitioner by giving him the benefit of the doubt to start with.[255] In *Daniels v Burfield*, Bollen J dispensed with this matter quickly by stating simply,

> 'The answer whether [due care was exercised] or not will depend on an examination of the facts or suggested facts. The onus of proof lies on the plaintiff. It is the "civil" onus.'[256]

The onus of proof is on the plaintiff and the standard of proof is on balance of probabilities. This onus of proof shifts onto the doctor if he negligently failed to take a precaution and the condition that the precaution was designed to circumvent eventuates.[257] Because damage is a necessary element of the claim and because it is the plaintiff who brings the case and makes the allegation of negligence, the burden of proof rests with the plaintiff to show that had she been warned of the risk which eventuated, she would not have undergone the treatment and therefore would not have suffered the injury of which she complains.

Considering the onus in negligence claims, Innes CJ in *Van Wyk v Lewis* said, 'The question of *onus* is of capital importance. The general rule is that he who asserts must prove. A plaintiff therefore who relies on negligence must prove it.'[258] This onus may differ in assault and battery cases. According to *Marion's Case* in Australia, in battery cases the onus is on the defendant to prove that the pursuer consented.[259] This is because physical contact or the threat of contact is *prima facie* unlawful. However, considering trespass to the person, *Freeman v Home Office*[260] held that the onus is on the plaintiff to prove that he did not consent.

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[254] See Jones MA 'Medical Negligence - the Burden of Proof' (1984) 134 *NLJ* 7.
[255] *Hills v Potter* [1983] 3 All ER 716, [1984] 1 WLR 130.
[256] 1991 AUST SASC LEXIS 1769.
[257] *Clark v MacLennan* [1983] 1 All ER 416.
[258] 1924 AD 438, 444.
[259] *Marion's Case*, (1992) 175 CLR 218, 233 et seq.
[260] [1984] 1 All ER 1036, [1984] 2 WLR 802 (per McCowan J at 537-7 and per Sir John Donaldson at 557 [QB] respectively).

Although there appears to be a lack of consensus in the Commonwealth, what this does show is a difference in the patient- or physician-orientation of the courts in Australia and England. There is uniformity across the Commonwealth, however, on the fact that the onus in negligence cases lies with the plaintiff and that this gives the practitioner something of a head start.

Different to the question of onus is the question of responsibility. While the injured party bears the onus of proof, legal responsibility is not necessarily borne by the individual medical practitioner due to vicarious liability. Where vicarious liability is imposed, the person directly responsible for the injury – in this instance the practitioner who omitted to give information on which consent was based – is not the named defendant.

The issue of vicarious liability and how it affects medical practitioners is an important one because it, too, is imposed for policy reasons. The court in *Launchbury v Morgans*[261] argued that vicarious liability is imposed for the protection of the plaintiff in order to provide the victim of an unintentional tort with someone who has the means to pay compensation. Additionally, it is psychologically easier to sue hospital authorities because of the perception of the hospital as institution.[262] This is especially so because the money paid in damages will not come from the pocket of the practitioner involved in allegedly negligent treatment.

According to the rules of vicarious liability, to establish whether an employer is vicariously liable to an injured person it is necessary to establish that the wrong was committed by a person who was an employee and who was acting in the course of his or her employment. This is the position in all jurisdictions discussed here.[263]

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[261] [1973] AC 127 (HL).

[262] It may be psychologically easier, but it is incorrectly seen as such. This is incorrect because of the money paid by medical practitioners in insurance premiums.

[263] In Australia, the decision in *Ellis v Walsend District Hospital* ([1990] 2 Med LR 103, 109 *et seq.* and 126 *et seq.* on applicable categories and definitions) provided a summary of Australian, Canadian and English legal development on the matter to find that once it is established that the surgeon or doctor involved was acting in the capacity of servant of the hospital or health authority, the authority is vicariously liable for the torts of that servant. That hospitals are vicariously liable for the delicts of their servants is a position taken in South Africa

1.5. DEFENCES

Other than the complete defences of emergency, necessity and therapeutic privilege,[264] defences open to the doctor on charges of negligence relate simply to the facts and to the rebuttal of evidence led by the pursuer who bears the burden of proof.[265] A defender will be successful in their defence by asserting, on balance of probabilities, a deficiency in any of the *facta probanda* of a negligence suit. For example, a defender would seek to lead evidence that the relationship between the parties was not close enough to found a duty of care. Failing that, the defender would lead evidence that although a duty of care existed between defender and pursuer, the defender was not in breach of that duty, and hence not negligent. In the last instance, and failing the first two lines of defence, the defender might seek to prove that the injury was not factually or legally caused by his negligent failure to inform the patient on the medical procedure to be followed. In South Africa, the defence of *volenti non fit iniuria* is available.[266]

In many cases, however, the defender need not assert anything because of where the burden of proof is positioned. Thus the pursuer's failure to prove the necessary elements of a claim in negligence would mean that their case would fail and no defence would be necessary in a situation in which the only burden is that of evidentiary rebuttal. However, following the plaintiff's case, the defender will bear not an evidentiary burden, but a persuasive or tactical burden.[267]

1.6. POLICY CONSIDERATIONS AND THE DUTY OF CARE

The relationship described in this chapter and in Chapter 2 gives rise to a duty of care; be it based on a fiduciary duty or on a relationship of proximity, and as long as the *volenti* defence

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in *Lymbery v Jefferies* 1925 AD 236, *S v Kramer and Another* 1987 (1) SA 887 and *Pringle v Administrator, Transvaal.* 1990 (2) SA 379.

[264] Though it is difficult to imagine the first two of these three defences arising in disclosure cases, because the very notion that it was either necessary or a matter of urgency to omit to disclose information on a material risk is paradoxical and non-sensical.

[265] It is not necessary to discuss each rebuttal in a section such as this because they will be discussed throughout this thesis.

[266] As discussed in 3.3.3., 4.7., 5.4.3. and 6.4.2.

does not apply or is not proven. The policy implications in the act of holding that a duty of care exists, may be interrogated by considering whether, within that duty of care, there is a duty of disclosure. In Australia and in Canada the duty of care is seen as different from the ordinary duty of care, while in England it is seen as part of the duty of care in medical practice. This will be discussed more fully in Chapter 3, but for present purposes those policy considerations in the general framing of the duty of care are worth a mention.

In Common Law countries, law is made by Parliament and applied and adopted by the judiciary. Judges are unwilling to be seen to be adopting a legislative role - or so the rhetoric of the judiciary would have us believe. In reality, the hands of judges are not as tied as we are encouraged to suppose; it is the judge who is able to determine in many instances the direction which society is to take. This is done through the enunciation of a new rule or legal test (often to replace an older rule on the matter) or the elaboration of an old rule to cover novel situations.[268]

The task of the judge is to determine whether a new rule is necessary and whether its adoption will fit within existing legal and social parameters. Holding that a duty of care exists in the context of the doctor-patient relationship is uncontroversial because of the case law which has elaborated that precept on the basis of 'community values' or the 'legal convictions of society' which the judiciary will interpret and define more precisely. This trend is not universal and, as this thesis will argue, it is more in evidence in South Africa, for example, than it is in British jurisdictions.[269] Ronald Dworkin argued that judges should be confined, in their law-making function, to questions about rights - that is the judge's evaluation of social values and of fairness.[270] The ultimate question here would be: does the plaintiff, in the context of

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[267] For the differences between these burdens, consider *Parr v HMA* 1991 SCCR 180 and *Mochan v Herron* 1972 SLT 218 in the criminal law context.

[268] Consider, in the criminal context, *Khaliq v HMA* 1983 SCCR 483 which (in the opinion of some academic writers) allowed Scots law to create new crimes, or (in the opinion of others) to adapt the existing common law to bring it in line with current or novel situations.

[269] Consider, in particular, 6.3.2.

[270] John Bell. *Policy Arguments in Judicial Decisions*. 1983. Clarendon Press. Oxford. 81.

informed consent, have the right to recovery based on the duty of care which this court holds to exist?[271]

This assessment by the judiciary is dependent on information available to the court at the time and is a very narrow and directed task because it is specific to the case before the court. John Bell outlined several factors which will be taken into account.[272] The court would have recourse to current social attitudes as they are practicably operable in the light of constitutional limitations already in place, and with a view to fairness, in balancing individual and community rights. As Bell put it,

> 'Apart from what can be gleaned from statutes and previous cases, discussion of social conditions and social attitudes takes place for the most part on the basis of unsupported assertions of social fact and projections of future benefits or disasters which would follow the adoption of a new rule, which rest on the judge's appreciation of human nature.'[273]

What this amounts to is an excuse which is dressed up as reasoning for adopting, or not, a new dictum such as informed consent in Britain.[274] Viewed less cynically, it is a way of saying that fears of the slippery slope will often justify not adopting a particular legal test.[275]

Lord Pearce in *Hedley Byrne v Heller*[276] said, '[h]ow wide the sphere of the duty of care in negligence is to be laid depends ultimately on the court's assessment of the demands of society for the protection of carelessness of others.' In disclosure cases, the court's policy of establishing the scope of the duty of care is crucial because it is the cornerstone on which the rest of the case will stand or fall. The Canadian position, for example, has construed the nature of the relationship between doctor and patient quite specifically as fiduciary while English courts have said that the duty of care exists, but that its definition is to be decided case by case

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[271] Cf. Chapter 6, particularly 6.3.1.

[272] Ibid. 69-76. These factors are outlined as encompassing social, administrative, constitutional and economic factors and those based on fairness.

[273] Ibid. 67.

[274] It is also the basis for slippery slope arguments and fears, which will be considered throughout this thesis, but particularly in 6.3.

[275] Cf. 6.2. on some American extremes of the doctrine of informed consent, which could constitute a reason not to adopt the doctrine.

[276] [1964] AC 465, 536. This case is considered analogous on this point because it considered information and liability for misinformation in the context of negligence, albeit in respect of an economic tort.

on the basis of proximity and by analogy with previous cases. We will see in the following chapters how this will affect the route taken by the courts in essentially very similar cases.

Policy, it should be noted, is employed after principle. This is evident from the nervous shock case of *McLoughlin v O'Brian*[277] in which Lord Scarman argued that the court decides the matter on the basis of existing principle but where principle gives no satisfactory answer[278] (or where required), recourse is had to policy.[279] However, the other Law Lords considered policy directly when they considered the possibility of a proliferation of claims of this sort coming to the attention of the court.[280] They left the test of the duty of care to be assessed relative to reasonable foresight and on a case by case basis. In this way they did not limit the scope in advance.

Within negligence (or by escaping from that delict in the case of South Africa) the policy-making role of the judiciary is prominent as policy arguments are raised by counsel and considered as such by judges. Because fault is an essential element of the claim, judicial policy will guide the future conduct of members of society, such as doctors. In considering medical negligence cases, the court looks at its own perception of the needs of society and balances that against 'slippery slope' or 'floodgates' arguments which may assert that were a certain rule to be adopted, the courts would face too many similar claims - or that the trend of claims would take a particular direction.[281] However, were the floodgates to be opened, that would point to a legislative role not having been fulfilled.[282] Other considerations against adopting a particular new rule are economic: the cost to the community of increased litigation and, in this case, to the medical profession of increased insurance premiums.[283]

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[277] [1982] 2 WLR 982, 998.

[278] As very often based on social attitudes and climate.

[279] It should be noted that subsequent to the judgement in *McLoughlin*, the House of Lords in *Caparo Industries v Dickman* [1990] 2 AC 605 held that reasonable foresight was insufficient to give rise to a duty of care alone, but that a relationship of proximity between the parties was necessary. The *Caparo* position has been upheld in the medical context in by the Court of Appeal *Osmond v Fergusson* [1993] 3 All ER 334 as well as by the court in *Palmer v Tees Health Authority* 45 BMLR 88.

[280] As was the case, for example, in the nervous shock cases brought following the Hillsborough disaster: *Alcock v Chief Constable of South Yorkshire* [1991] 4 All ER 907 and *Frost v Chief Constable of the South Yorkshire Police* [1997] 1 All ER 540.

[281] Cf. 6.2.

[282] Bell. Ibid. 71.

[283] Not explicitly taken into account by the judiciary.

The judge as the 'well-informed citizen' is in a position of great power in assessing the duty of care and hence the tort of negligence. If no duty of care is found to exist, the plaintiff's case will fail. However, if a duty of care exists, there may also exist in the law of torts a *prima facie* case for the plaintiff based on reasonable forseeability. Strong policy arguments will need to prevail in order to rebut that *prima facie* case. At that stage the court will make policy decisions to restrict the class of plaintiffs to whom such claims will be available or to limit the number of possible plaintiffs.

CHAPTER 2

DOCTOR, PATIENT, ILLNESS AND LAW

2.1. INTRODUCTION

Having considered the fact that the informed consent scenario is litigated in negligence, it has been concluded that a duty of care between patient and medical practitioner has arisen. This chapter will briefly consider some of the governing principles which are brought to bear in that relationship. It will consider the differing perspectives from which the litigating parties view that relationship. This well serve as a background from which to consider the policy considerations which the judiciaries bring to bear on disclosure cases so that, in Chapter 3, it will be possible to consider the judicial tests for standard of care within the duty of care. This chapter sketches the positions taken by the protagonists as background to that discussion and concludes with a discussion of judicial policy.

2.2. ETHICS, ETIQUETTE AND LAW

In the present context what is meant by *ethics* is a body of rules and principles, codified[1] or otherwise, which concerns the behaviour of professionals when dealing with and treating others in the latter's capacity as patient. *Etiquette*, on the other hand, denotes those codes of behaviour which are internal to the profession and which concern conduct among members of the profession. When it comes to the law, any *de facto* ethical situation needs to be raised to the *de jure* to legitimise a professional ethics in the eyes of the law.

In the context of consent based on information, the BMA has an idealistic view of the doctor-patent relationship, holding that such relations should be based on partnership.[2] It recognises the problems encountered in communication between the two. It sees consent to the initial examination as a *trigger to discussion*, within and regarding the therapeutic context.

[1] Such as the Hippocratic Oath, restated in the Declaration of Geneva; the International Code of Medical Ethics based on the Geneva Convention; the Declaration of Helsinki regarding new and experimental treatments and the publications and guidelines of each of Britain's Health Authority Ethics Committees.

[2] British Medical Association. *Medical Ethics Today: its Practice and Philosophy.* 1993. Ch.1.

Interestingly, the BMA sees this two-way process as allocating rights to the patient as well as to the doctor and it sees consent as an issue which 'binds legal and ethical considerations'.[3]

The BMA draws members' attention to a passage in the 1981 Declaration of Lisbon, which reads: 'the patient has the right to accept or refuse treatment after receiving adequate information'. It then points out that the ethical demand of this precept ought to be to supply as much information as the patient needs or desires. The BMA drew on Lord Scarman's dissenting opinion in *Sidaway*[4] in which he set out the admittedly ideal 'prudent patient' test regarding information as that which 'allows the patient to make a rational decision.'[5]

This is curious precisely because it was a dissenting opinion. If the ideal of the profession's trade union is not the law, this says much about what the law should be and the direction in which we might see the law to be moving within the paradigm of the doctor and patient as litigants. It also speaks volumes about how the medical profession sees the ideal legal position.[6] While the patient's views are to be taken into account to a greater degree, the amount of information required is decided by the doctor, whose duty should require him to consider views of the subjective patient. This suggests a difference between the thinking of lawyers and that of doctors; this difference is important at many stages in the litigation process and so worthy of some consideration.

Professional ethics and law do not necessarily adopt the same stance on every matter. The most recent edition of *Good Medical Practice* purports to recognise that 'doctors have wider professional and ethical responsibilities than the law requires them to have.'[7] This thesis does not propose to delve deeply into the jurisprudential debate on the differences and similarities between law and ethics. Suffice to say that at times medical law may pre-empt ethical conduct and affect medical practice. Information disclosure cases serve as examples of this because the medical community is inclined to avoid legal liability by bringing their conduct in line with courts' decisions on the matter. The conduct of doctors is regulated and governed

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[3] British Medical Association. 3.
[4] *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871, 876 et seq., [1985] 1 All ER 643, 645 et seq.
[5] British Medical Association 10-11.
[6] Which is not as much in the interests of the profession as the present English and Scottish positions. Cf. Ch.32.
[7] Sir Donald Irvine, president of the GMC, quoted by Linda Beecham in *British Medical Journal* 1998; 316: 1553 (23 May).

by the mechanisms of law and ethics. When the two are at odds, and someone is harmed, cases may come before the courts. This argument emphasises the importance of the forms of legal testing used in all cases and the weight given by courts to the practices of the medical community, particularly, in this context, in respect of tests for medical negligence.

Two types of medical negligence need to be separated: negligence based on the treatment received or withheld, from negligence based on a wrongful omission to inform a patient of risks inherent in, and alternatives to, the proposed treatment.[8] Foremost in the equation a doctor ought to know what he is talking about and particularly what he is doing. Yet in the medical profession it is increasingly important to relate to consumers as well as to be technically and intellectually competent.

The law has various ways of looking at the medical practitioner according to the position in which the law holds him: as defendant to an action, as an expert medical witness in a similar or unrelated action or as an object to be regulated by legislature and judiciary.

Most instances of medical negligence fall completely within the civil law arena - the neighbourhood principle in which negligence[9] involves a duty owed and the breach of that duty which causes injury for which the tortfeasor pays damages. At this point in the discussion it is sufficient to note that the standard of care in the law of torts or delict will be governed by the applicable raised professional standard of care, which might reasonably be expected of someone with similar professed qualifications and attributes. The medical profession will be separate from other occupations and professions because it comprises different knowledges, functions and forms of control. But some common legal rules are still applicable, such as those which govern professional liability generally.[10]

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[8] What this thesis has described as the 'informed consent scenario' (Cf. 1.1.) which is generic and typical of most cases discussed here.

[9] A tort or delict. This aspect will be more comprehensively covered in Chapter 3 when the discussion turns to specific liability and responsibilities. Suffice to note here that informed consent is not always a simple matter of the tort or delict of negligence, as the South African example will illustrate.

[10] See Jackson and Powell.

Law increasingly involves itself in determining the activities of medical practitioners, especially their decision-making powers.[11] Teff suggests that law is the only discipline that makes use of bipolar argument to determine facts,[12] so showing itself to be different from either scientific or medical thinking. This aspect of legal thinking differs from medical thinking and may alienate practitioners in the courtroom.[13] In the final analysis, the lawmaker holds the royal flush; yet as we shall see, the extent to which courts are content to leave anything up to medicine varies across the jurisdictions. It is for this reason that a comparative methodology is considered a fitting one.

2.3. MEDICAL THINKING

Medical thinking is not a linear process and is unlike thinking styles in either the pure sciences or the humanities. Two argued assumptions are made here: that diseases as such do not exist and that medicine is not a pure science; hence that medical thinking is different from legal or lay thinking.

Even although a disease condition does exist, diseases per se do not exist in a state of nature. As technology exposes them to scrutiny, they are seen to evolve[14] and change form and manifestation. Names and manifestations of diseases are man-made. As diseases they are didactic constructions of biomedicine for use among practitioners. By the term *disease* we mean a name that encompasses signs, symptoms and conditions as well as a dynamic condition specific to the patient. When talking about the risks involved in the treatment of a specific disease condition, the multiple variables in the equation need to be reduced by considering those variables as specific to the particular patient.[15]

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[11] Teff, H *Reasonable Care: legal perspectives on the Doctor-Patient Relationship*. 1994. Oxford University Press. Oxford. 3. See also *Re S (Adult : refusal of treatment)* [1992] 3 WLR 806, in which a caesarean section was performed contrary to the patient's wishes and religious convictions. This was an unfortunate case on a position which is no longer the law in England, as the Court of Appeal confirmed in *St George's Healthcare NHS Trust v S, The Times*, 8 May 1998.

[12] Teff 10-12.

[13] Cf. Chapter 5 on the expert.

[14] Zajicek, G. 'Normative Medicine' (1995) 45 *Medical Hypotheses* 331-334, 331. In the context of psychiatric illness, see also Thomas Szasz 'Diagnoses are not Diseases' (1991) 338 *Lancet* 1574.

[15] This forms an initial argument for patient-centric legal tests based on the *modus operandi* of the doctor; what is described here as the generic informed consent scenario.

This underlines the importance of communication and of nomenclature when dealing with a patient. The lay person cannot see medical issues in the same way as can the endogenous practitioner or, as Cohen and Schnelle put it, 'he looks, but he does not see.'[16] This is because of the specific thought style of the *thought-collective* of practitioners.[17]

Medicine is largely dependent on accurate communication both between doctor and patient and among medical colleagues, because perceiving will always be a directed activity. Fleck argued that language goes beyond communicability; he said, 'that which I express is always different from that which I think. In the same way, that which is understood is always different from what I have said.'[18] Science has the task of simplifying and generalising to achieve comprehension.[19] This is of crucial importance when it comes to communication of those medical facts which form the basis of the information required for true consent and any *sine qua non* legal test.[20] It is also important when it comes to the plaintiff reporting to a court what was said in the exchange between doctor and patient - which forms the subject of a legal dispute involving consent and information on risks and alternatives.

What is required is the extraction of meaning from the information present. In the context of the clinical encounter, the term *information* must be extended to include the results of intuition and experience; the intention being to turn 'informed consent' into 'understood consent'.

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[16] R S Cohen & T Schnelle (Eds.). Cognition and Fact: Materials on Ludwig Fleck. xxi.

[17] A term coined by Ludwig Fleck.

[18] Cohen & Schnelle xxviii. See also Dieter Wittich 'On Ludwig Fleck's Use of Social Categories in Knowledge' in Cohen & Schnelle 317 et seq.

[19] Communication and understanding will prove pivotal in the informed consent case. The medical practitioner has the task of translating and communicating medical information which forms the basis of the patient's decision whether or not to undergo the treatment proposed. The patient must then communicate this choice to the doctor. This is not usually a problematic stage of the process unless, for example, the patient is aphasic (though not sufficiently so as to be regarded mentally incompetent and, hence, excluded from consideration by this thesis) and has a condition common among aphasics in which 'yes' and 'no' answers are at times reversed. In such a circumstance, a speech therapist would be needed to serve as an interface between doctor and patient. This is an extreme example of an everyday situation not unknown to the NHS. In the context of language translation, it has been recognised that inadequate resources have been 'devoted to communication and information services' and that this leads to a 'much impaired service for patients from minority ethnic groups.' Watt I S, Howell D & Lo L, 'The health care experience and health behaviour of the Chinese: a survey based in Hull.' (1993) 15 *Journal of Public Health Medicine* 129-136 cited in *British Medical Journal* (Editorial) 1998; 316: 1476-1480 (16 May).

[20] Cf. Chapter 4 on Causation and Chapter 3 on The Consensual Patient.

2.4. PATIENT THINKING

Patient thinking refers to the patient's attitude or state of mind: that of a person of inferior medical knowledge and skill to the practitioner who acts in a system of health care characterised by bureaucracy. One of the demands of the Patients' Movement has been that of control of treatment.[21] This occurs *inter alia* at the point of consent. The patient's case is that the profession expects consent to be granted unquestioningly and on the advice of the doctor because it is more a clerical task than an ethical demand. The argument would go on to assert that with a particular piece of information, consent would have been refused.[22]

These demands have been attacked by professional bodies on the grounds that patients do not want the responsibility, that they do not understand the medicine involved and that explaining would take too much time. These criticisms and their answers are additional factors highlighting the importance of communication between doctor and patient of risks, alternatives and recommendations prior to both consent and to treatment.

It is in this context - differences between legal, lay and medical thinking - that one can look more critically at the story that gave rise to the case of *Reibl v Hughes*[23] in Canada. As already mentioned, Canada was the first common law jurisdiction outside of America to take the doctrine on board. In the report of the case, *Reibl v Hughes* contained excerpts of the dialogue between legal counsel and both plaintiff and defendant. That dialogue highlights the importance of accurate communication between patient and medical practitioner.

Reibl v Hughes concerned the alleged omission by a neurosurgeon, to warn his patient that surgery to remedy an occluded artery could, in ten per cent of cases, result in a stroke, regardless of the competence of the surgical technique. Ironically, Mr Reibl had been advised that surgery was indicated to prevent a stroke in later life. Of importance is that it was not alleged that the surgery had been performed negligently. The pleadings alleged that negligence comprised the failure to inform of the risk which eventuated. This comprised an ideal platform

[21] Watkins, S. *Medicine and Labour*. 1987. Lawrence and Wishart. London. 160-161.
[22] Cf. Chapter 4 on causation, especially on legal or hypothetical causation and on hindsight.
[23] (1980) 114 DLR (3d) 1.

for the Court to employ a different test for disclosure cases from that employed in negligence *simpliciter* cases, which it did, so marking a contrast with British jurisdictions.

Several elements both complicated matters for the court and serve to illustrate the difficulties encountered in disclosure cases. These difficulties have to do with the respective memories of the litigating parties. Communication between doctor and patient usually involves using lay terms to describe symptoms, diagnosis and prognosis. Mr Reibl's case was further complicated by the fact that he was of Hungarian extraction and did not speak or understand English very well. This in itself meant that what the surgeon had said to Mr Reibl was not necessarily that which was understood by Mr Reibl.

The case serves as an example of failure of communication between doctor and patient. In evidence, Mr Reibl said that he did not know what a stroke was; it had been explained to him in terms of falling on his nose. Any explanations given to Mr Reibl were not understood as explanations of the risk of stroke inherent in the recommended surgery. Instead, they were understood as warnings against leaving the condition untreated. This meant that Mr Reibl did not benefit from information which would have changed his decision on whether to undergo surgery at that time. Indeed, he gave evidence to the effect that had he known of the ten per cent risk of stroke, he would not have had the treatment at that time because he was very close to retiring on full pension.

Whether communication between doctor and patient comprises a legally adequate warning is the question for the court which will be discussed in this thesis. Courts in each jurisdiction will have to ask whether the standard of care met with the standard set by judicial tests in negligence or indeed tests for whether there had been an informed consent.

This thesis will be comparing the approaches of several common law jurisdictions in broadly similar circumstances, though not in respect of different mother tongues. The case highlights many of the issues with which this thesis is concerned. Though cases heard in other jurisdictions have involved a lesser need for linguistic translation, they have involved the need for translation from medical discourse into lay terms. In many of the cases which will be discussed, Counsel will have called upon the court to adopt the approach of another analogous

jurisdiction. The jurisdictions generally compared by judiciaries are those which are included in this thesis.

2.5 THE LAW AND THE RULES

The law has various ways of looking at the medical practitioner according to the position in which the law holds him: as defendant to an action, as an expert medical witness in a similar or unrelated action or as an object to be regulated by legislature and judiciary. There are differences between legal regulation and quasi-legal regulation by the legally enabled GMC. However, both sets of regulations comprise a concrete body of rules, a mechanism to check adherence and the power to impose some form of sanction on offenders; so both are consistent with Durkheim's formulation that legitimate sanction is the primary index of regulation.

The General Medical Council can maintain an effective sanction by removing or threatening to remove a practitioner's name from the register.[24] This is by virtue of the 1983 Act rather than by virtue of keeping the register; the act delegates the power of sanction to a legally enabled authority. The two have analogous systems of contesting and arguing the matter in the form of tribunal or court proceedings, which involve witnesses and representation. These forms may be considered under the genus *regulation* but will be looked at severally in order to isolate the form of legal regulation with which this thesis will go on to deal.

Tensions arise in medical practice from a demand for occupational skills from a heterogeneous consumer group which is both dependant and exploitable. This is because of the monopoly of knowledge held by doctors and the demand for care expressed by patient-consumers. These conditions developed in England in the second half of the nineteenth century in association with an increase in the market power of the middle class.[25] As this middle class began to sponsor more recruits to the profession, the producer-consumer relationship became a more fiduciary one, initiated by the ailing client and terminated by the healing professional. At this point a modern ethics arose, which was derived from beliefs internal to the association.

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[24] As they are empowered to do by the Medical Act 1983.
[25] Johnson 52.

This association had the twin collegiate functions of defining standards of conduct and of developing homogeneity in practice.

An altruistic professional identity is required in the perception of both the professional person and the public. Durkheim argued that no social activity can do without moral discipline and in the cohesive group context this often takes the form of a code, which has the function of protecting collective interests.[26] Such codified conduct is ostensibly more about expertise than about commercial interest, yet it remains tainted by the latter. Such guidelines serve as cohesive agents; the necessity for this cohesion is proportional to the size of the group.[27]

The General Medical Council is responsible to the Privy Council for the registration of practitioners who are defined as those who appear as such in the register of the GMC.[28] There have been various Medical Acts in England,[29] but the most important in this context is the 1983 act, which concerns the composition and functions of the GMC. It consolidates and in part repeals the others such that it is *currently* the most important. In the context of a National Health Service and state control, if a practitioner is not on the Register, he or she cannot practice with the NHS.[30] In terms of education, the GMC undertakes inspection of curricula and recognition of qualifications according to requirements, which are contained in the Medical Act 1983.[31]

The GMC was formerly not concerned with medical negligence per se unless standards fell low enough to bring the profession into disrepute,[32] in which case the conduct in question would have to be considered 'disgraceful or dishonourable by a doctor's professional brethren

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[26] Durkheim 14-15.

[27] In medicine this amounts to a caring profession caring for a profession and has the function of confronting the individual doctor with aims which are not necessarily his own.

[28] Jackson, Rupert M. & Powell, John L. *Jackson and Powell on Professional Negligence* (3ed). London. Sweet & Maxwell. 1992. 447. However, in England it is not necessary to be qualified with, educated by or registered with GMC to practice - unlike analogous restrictions placed on dentists and vets.

[29] 1950, 1978, 1983.

[30] This also applies, by reciprocal arrangements, to practitioners from Australia, Canada, New Zealand and South Africa practising in the United Kingdom, so accepting qualifications in those states as analogous.

[31] See Hall, O. 'The Internal Organisation of the Medical Profession' (1946) 22 *Canadian Journal of Economics and Political Science*.

[32] Gee, D J & Mason, J K *The Courts and The Doctor*. 1990. Oxford University Press. Oxford. 174.

of good repute and competency'.[33] This indicates that the professional standard is both a legal and a professional one.[34] Now, however, the GMC has an explicit concern with medical negligence as stipulated in the Medical Professional Performance Act 1995.

The disciplinary ambit of the GMC on serious professional misconduct is both punitive and intended to protect the public. Sanctions available to the GMC are very real to the practitioner because imposition could end a career.[35] The GMC does not list the main categories of Professional Misconduct[36] but they remain theoretically limitless. The Ethical Committee of the British Medical Association also has an interest in codifying,[37] publicising and enforcing ethical considerations but it remains a trade union responsible for the interests of its members and as such can neither enforce ethical codes nor expel members.

It would appear, therefore, that the medical profession in Great Britain has the statutory authority to regulate itself. It will become apparent in Chapter 3 that this self regulation has judicial sanction to some extent through the power and authority of the *Bolam* test. This judicial test for negligence assesses the practitioner's conduct relative to the conduct of other similarly qualified medical practitioners, as attested to in the evidence.[38] This thesis will go on to note that other jurisdictions covered use a *Bolam*-style test in respect of negligence *simpliciter*, but a different test in respect of disclosure cases. British judiciaries, on the other hand, use the same test in both types of case. It will be argued, therefore, that Britain is the most paternalistic of the jurisdictions under discussion and that this paternalism is due to the fact that the medical profession has been able to regulate itself. The one *caveat* to this argument is that British courts retain the authority to assess the evidence given in terms of reasonableness.[39] This thesis will then go on to argue that British judicial tests allow more scope for self-regulation than do tests in other jurisdictions.

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[33] GMC. Professional Conduct and Discipline: Fitness to Practice. 1987. Paragraph 6.
[34] In informed consent cases in Britain. Cf. Chapter 4.
[35] Sanctions may involve removal from the register, postponement of registration or probationary registration.
[36] Professional misconduct can be considered as that which amounts to abuses of the physician's privileges and training. See J K Mason 'Legal Aspects of Medical Practice' in *Forensic Medicine for Lawyers.* 436.
[37] For example, BMA. *Medical Ethics Today.* 1993.
[38] Cf. 5.3.3. which will consider the British medical profession as something of a 'mutual protection society.'
[39] Cf. 3.2.1., 3.3.4., 3.3.5., 4.3., 4.4. and, most importantly, 5.4.4. This re-emphasised in the conclusion to this thesis in 7.2.5. and 7.3.

Sidaway,[40] and indeed all other cases of this type, simply accepted the relationship between doctor and patient as sufficiently proximate to found a duty of care.[41] English and Scottish[42] courts do not dispute whether a duty of care exists;[43] but they do test the standard of care within that general duty differently to other jurisdictions. Conversely, in Canada in *Arndt v Smith*[44] the British Columbia Court of Appeal pointed out that in *Hopp v Lepp*[45] Laskin CJC had adopted a different test for informed consent from that taken up in *Sidaway*. This was based on the '[adoption of] a test based on a different view of the relationship of doctor and patient'. It is this relationship of unequal power and knowledge that gives rise to a common law duty of care or indeed to fiduciary duties in Canada.

Whereas Lord Scarman based this relationship on the doctor's duty of care giving rise to corresponding patient rights, Appeal Judge Lambert in *Arndt v Smith* noted that in *Hopp v Lepp* Laskin CJC had relied on *Kenny v Lockwood*[46] and *Halushka v University of Saskatchewan*.[47] In *Arndt v Smith* it was held that 'disclosure obligations of a doctor to a patient were considered to flow from a fiduciary relationship between the doctor and the patient.'[48]

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[40] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 (HL), 649 where Lord Scarman outlined the *Bolam* test. Cf. Chapters 1 and 2.

[41] Cf. 2.3. and Chapters 1 and 3 generally on the standard of care.

[42] Consider *Gordon v Wilson* 1992 SLT 849, *Moyes v Lothian Health Board* 1990 SLT 444, *Jones v Lanarkshire Health Board* 1990 SLT 19.

[43] However, courts have had to consider he matter of a duty of care in the medical context. In *Goodwill v British Pregnancy Advisory Service* [1996] 2 All ER 161 it was held that a surgeon has no duty of care to an unspecified woman who may, at some time in the future, rely on his expertise. This case concerned pregnancy following failed vasectomy done before the man and woman had met. For a comprehensive, if non-medical, discussion by the House of Lords on the duty of care in the English law of torts from the case law on the subject, consider, *inter alia*, *Donoghue v Stevenson* [1932] AC 562, *Dorset Yacht Co. v Home Office* [1970] AC 1004 and *Caparo Industries PLC v Dickman and Others* [1990] 2 AC 605.

[44] [1995] 7 Med LR 108, 113 and 116 (col. ii).

[45] (1986) 112 DLR (3d) 67, [1980] 2 SCR 192, 210.

[46] [1932]1 DLR 507 (Ont. CA).

[47] (1965) 53 DLR (2d) 436.

[48] *Arndt v Smith* [1995] 7 Med LR 108, 113 (col. ii). On the fiduciary nature of the relationship between doctor and patient, consider *McInerney v MacDonald* [1992] 2 SCR 138; *Norberg v Wynrib* [1992] 2 SCR 226; *Goodman Estate v Geffen* [1991] 2 SCR 353 (at 370 on categories of influence of a doctor on a patient). On causation principles and their application in fiduciary relationships see *Kenny v Lockwood* [1932] 1 DLR 507 and *Halushka v University of Saskatchewan* 53 DLR (2d) 436.

It was held that in the area of communication of risks, a relationship is fiduciary where it 'has the characteristics of such a relationship: reliance, vulnerability, and trust, on the part of the patient, and skill, responsibility, and power on the part of the doctor.'[49] Lambert JA then said,

> 'The conclusion which seems to me to follow from those two points is that the duty of disclosure of material risks or of special or unusual risks is not like an ordinary duty of care in negligence, because it is not set by the standard of the reasonable medical practitioner, but is more similar to a fiduciary duty of disclosure, where the standard is set by utmost good faith in the discharge of an obligation by a person in the position of power and control to a person who is vulnerable, in a position of dependency, and is known by the doctor to be in a position of reliance.'

This is so because of the court's recognition that the verbal exchange between doctor and patient in this fiduciary relationship hinges entirely on the quality of communication, as demonstrated in the case of *Reibl v Hughes*.

Having found that the basis of the relationship between what become the litigating parties is fiduciary in nature, the court has a specific legal and procedural mechanism with which to found liability.[50] This could have an effect on the test for causation insofar as the same principles applicable to causation in a fiduciary relationship will be applicable when considering informed consent.[51] On communication, the decision in *Hopp v Lepp* set the standard in Canada and rests its reasoning on the fiduciary nature of the relationship.[52]

These cases were something of an advance on *Reibl v Hughes* in which Chief Justice Laskin had said merely that it was,

> 'undoubted that the relationship between surgeon and patient gives rise to a duty of the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery which is recommended.' [53]

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[49] Ibid. 116 (Col. ii).

[50] The same is true of a duty of care in negligence in which precedent will determine what tests are to be applied once it has been found that one party owed the other a duty of care.

[51] Ibid. 116 (Col. i). See also categories of influence discussed by Madam Justice Wilson in *Goodman Estate v Geffen* [1991] 2 SCR 353. Cf. Chapter 4 on Causation.

[52] Citing *Kenny v Lockwood*, *Halushka v University of Saskatchewan*, *McInerney v MacDonald* and *Norberg v Winrib*.

[53] (1980) 114 DLR (3d) 1, 5.

He then debated materiality and the scope of that duty of care according to tort principles. Where the advance came was is in the court's ability to consider the scope of that duty relative to a relationship, which the court itself held to be fiduciary.[54] These cases set out the basic principles on which the legal responsibility for failure to warn a patient of material risks lies. It is a matter of policy to characterise the relationship in that way, so making it easier for the court to move in the direction in which this thesis will show it to have moved.

Australian courts also considered whether the relationship is a fiduciary one. In *Rogers v Whitaker* the court held that there was, in the context of the relationship between doctor and patient, a duty to warn of inherent dangers in the proposed treatment and that there was no 'dispute as to the existence of a duty of care on the part of the appellant to the respondent'.[55] The court did this on the basis of proximity and the law of torts. The court went on to consider the scope of that duty, without specifically placing it in the context of equity as a fiduciary duty. *Breen v Williams*,[56] however, did consider the nature of the relationship. The case involved access to medical records. It was submitted that this right was based variously on contract, property and a fiduciary duty. It was held, on appeal, that none of these bases gave any support to the appellant's claim for access to medical records.

Brennan CJ, in arguing the point, noted that fiduciary duties arise either from agency[57] or from 'a relationship of ascendancy or influence by one party over another, or dependence or trust on the part of that other',[58] but that these categories may overlap.[59] He went on to say, 'It is erroneous to regard the duty owed by a fiduciary to his beneficiary as attaching to every aspect of the fiduciary's conduct, however irrelevant that conduct may be to the agency or relationship that is the source of fiduciary duty.' Considering what he termed 'the nature of the doctor-patient relationship', he held that it,

> 'is one where the doctor acquires an ascendancy over the patient and the patient is in a position of reposing trust in the doctor. Such a relationship casts upon the doctor the onus of proving that any gift received from the patient was given free from the influence

[54] This will be considered in Chapters 3 and 6.
[55] [1993] 4 Med LR 79, [1992] ALJR 47.
[56] See [1995] 6 Med LR 385, 399 col. (i) et seq. For the judgement of the Supreme Court of New South Wales. The patient was not allowed access to her medical records based on contract, human rights, fiduciary duty or equity. In addition, her appeal was dismissed by the High Court of Australia F.C. 96/025. LEXIS.
[57] Drawing on *Birtchnell v Equity Trustees, Executors and Agency Co Ltd* (1929) 42 CLR 384, 408- 409.
[58] Drawing on *Johnson v Buttress* (1936) 56 CLR 113, 134-135.
[59] Considering by way of example *United Dominions Corporation Ltd v Brian Pty Ltd* (1985) 157 CLR 1, 12-13.

> which the relationship produces.[60] But in this case the doctor has received no gift; he has taken no step to procure an advantage for himself. Nor has he taken any advantage of his ascendancy over his patient or of her trust in him.'[61]

In Canada, the Supreme Court in *McInerney v MacDonald*[62] had held that the fiduciary duty gives rise to a duty to produce medical records on demand. Brennan CJ noted that the notion of the fiduciary duty in Canada was quite different from that in the United Kingdom[63] and in Australia. This decision of the Australian High Court shows two things. Firstly, it demonstrates a greater proximity of Australian civil law to English law than that of Canadian to English law. Secondly, it casts the Canadian dicta articulated relative to the fiduciary duty in *Arndt v Smith* and *Hopp v Lepp* in a starkly policy-guided light. Characterising the relationship as a fiduciary one is the first step to reforming the law in a direction which the judiciary considered desirable.

The South African position is broadly similar to that in England on this point although *Castell v DeGreef*[64] did remove the matter from the realm of negligence by distinguishing the South African position from that in England and Australia. The Supreme Court held that in such matters the defence of *volenti non fit iniuria* was available which, if proven, 'would justify an otherwise wrongful delictual act.' This is available in the law of delict in South Africa and, *volenti* being proven, the defender will be held to have fulfilled the duty of care.

This methodology changed the law in South Africa on the ground of policy by removing the issue from the confines of negligence and allowing the court to establish consent criteria through the *volenti* mechanism.[65] Because this case removed the matter from the context of negligence, the issue of a proximate or even a fiduciary relationship founding a duty of care did not arise. This is because information given is a question of fact and evidence. However, Ackerman J did say that 'on either approach the same, or virtually identical, matters of legal policy are involved'.[66] He drew on the Australian case of *F v R*[67] in which it was

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[60] Again from *Johnson v Buttress* (1936) 56 CLR 113, 134.
[61] LEXIS report, point 15 of the High Court of Australia judgement per Brennan CJ.
[62] (1992) 93 DLR (4th) 415, 424.
[63] *R v Mid-Glamorgan FHSA; Ex parte Martin*, [1995] 1 WLR 110.
[64] 1994 (4) SA 408, 420H read with 423C-D.
[65] 1.2.2.4. considers the removal of informed consent matters from negligence in South Africa.
[66] 423C-D.
[67] (1983) 33 SASR 189.

observed that the scope of the doctor's duty involved two values which may conflict: the duty of the doctor and the right of the patient.

However the relationship between doctor and patient is judicially viewed, the jurisdictions have several points in common. All view the relationship as an unequal one; all consider that the doctor has a duty to give information to the patient on that patient's condition and treatment and all implicitly recognise that the accuracy of communication becomes the point of dispute between the litigating parties. It follows, therefore, that accurate communication is central to redressing the imbalances within the doctor-patient relationship. It is perhaps for this reason that the issue of informed consent has been dominated by rights discourse.[68]

2.7. CONCLUSION: PROFESSIONAL RESPONSIBILITY

This chapter has set out to investigate the different perspectives from which doctor and patient will approach the consultation. By implication, accurate communication between the parties will have emerged as being of central importance. Having situated informed consent cases for the most part in negligence, and having considered some of the communication difficulties which are faced in the doctor-patient relationship which gives rise to a duty of care, it will be possible in the next chapter, to use the framework of the law of torts or delict to consider the professional responsibility of doctors and the *standard* of care.

This is another of the points at which legal policy is made through judicial definitions of the scope of the duty of care.[69] Now that it has been established it is possible to focus on the following question: in the context of the informed consent scenario sketched at the beginning of this Chapter, and with regard to the facts of the case before the court, what is the scope of the duty of care owed by the medical practitioner to the patient? This is the fundamental question of the standard of care.

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[68] Cf. 6.3.1.

[69] As seen in the Introduction to this thesis in which the nature of the doctor-patient relationship (in the eyes of the court) was discussed and as will be seen in the next chapter on the consensual patient.

As the next chapter will go on to explain, this standard was set out in the case law in each jurisdiction under discussion. In England, the case of *Bolam v Friern Hospital Management Committee*[70] was upheld by *Sidaway v Bethlem Royal Hospital Governors*[71] as setting out the standard of care in respect of negligence *simpliciter* as well as negligence based on the omission to disclose a particular piece of information. The *Bolam* standard was itself a rewording of the test set out in *Hunter v Hanley*[72] in Scotland. *Bolam* and in *Hunter v Hanley* were adopted together as expressive of the standard of care in medical negligence in the case of *Moyes v Lothian Health Board.*[73] At this stage two elements are important: the first is that the same standard is to be used in respect of negligence *simpliciter* as should be employed in respect of information disclosure. The second is that the standard itself is such that the medical practitioner's conduct is assessed relative to his or her peers.

It is this standard that marks British judicial tests as different from those employed elsewhere. In Canada, for example, the standard of care in respect of information disclosure is that set out in *Reibl v Hughes,*[74] while the standard of care in respect of negligence *simpliciter* remains analogous to that set out in *Bolam.* The standard of care in respect of cases which have to do with information disclosure is based on the information that the reasonable person in the particular patient's position would require. It a matter of considering the case from an 'apparent subjective' or 'modified objective' point of view. A similar position is in evidence in Australia. There the method of assessment of information disclosure which was adopted by the court in *Rogers v Whitaker*[75] was based on what the reasonable patient in this patient's position would require *or* the information that could be reasonably be expected of the medical practitioner. In the South African case of *Castell v De Greef,*[76] the court used the test which had been expressed in *Rogers v Whitaker.* What is noteworthy is that these latter three cases employed a different test for the standard of care in negligence *simpliciter* from that employed in negligence based on information disclosure.[77] These cases, and those which preceded and

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[70] [1957] 2 All ER 118, 121.
[71] [1985] 1 All ER 643 HL.
[72] 1955 SC 200, 1955 SLT 213.
[73] 1990 SLT 444, [1990] 1 Med LR 463.
[74] (1980) 114 DLR (3d) 1.
[75] [1993] 4 Med LR 79.
[76] 1994 (4) SA 408.
[77] Cf. 3.2. on the fact that British jurisdictions employ the same test for both categories of negligence.

followed them, will be discussed more fully in the next chapter which will examine the standard of care in greater detail.

That an act or omission is wrongful presupposes a correct form of behaviour. Once the fact of the doctor-patient relationship has been established, the court determines whether the conduct of the defender fell short of the requisite standard of care. Here, as with the causation inquiry, there is a two-stage test. This comprises the assessment of the duty of care and then of the matter of its breach. It is at this point that there is a divergence of approaches in the jurisdictions under discussion. Only after this inquiry has yielded a result to the effect that there was a duty of care and that that duty was breached by the defendant's conduct, will it be relevant or necessary to establish a causal link between this negligence and the plaintiff's injury.[78] In all of these matters the court will remain the final arbiter of whether the requisite standard has been met, whatever the jurisdiction. This means that while the evidence of experts will be important to the court in assessing the facts, that evidence will be weighted by the court in different ways depending on the jurisdiction.[79] This is a matter of judicial policy, but regardless of the policy formulated, it is for the court to apply that policy through their own assessment of the evidence before them.

Having found that a duty of care exists between the medical practitioner and the patient, it is now possible to consider the *scope* of that duty of care in the context of negligence and, more specifically, in the context of those negligence cases which are based on an omission to disclose information, and hence on a lack of informed consent.

It has been argued on the basis of judicial assessment of the matter that the proper place for informed consent litigation remains with the tort or delict of negligence. This applies with the exception of cases of fraud or misrepresentation and, of course, the South African position.

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[78] MacFarlane P. *Health Law - Commentary and Materials*. The Federation Press, NSW, 1993:86. It would be rare in cases of medical negligence based on alleged lack of informed consent to come across a resultant injury which was unforseeable. Were that to be the case, however, it would be considered an 'act of God' which, in the law of torts, is a plea of innocence on the ground that the injury was beyond the control of the defender. This is more a denial of liability than a defence and only operates where *res ipsa loquitur* has been pleaded. However, because this is no longer likely to be the case (claiming inevitable accident as a defence or as a rebuttal of the of the presumption of negligence presupposed in *res ipsa loquitur*) it is considered that acts of God are not material to informed consent.

Citing *Sidaway*, Markesenis & Deacon have said that it could be argued that, 'the differences between battery and negligence ... have led to the policy decision to restrict the use of the tort of battery to the most opprobrious interferences with one's body, even though these policy reasons are rarely admitted in the open.'[80] A similar policy argument can be made on the court's exclusion of the tort of battery in *Reibl v Hughes*.

With the claim based in negligence, the burden of proof is on the plaintiff to establish the *facta probanda* of such an action. It has also been argued that three steps in judicial policy-making have been in evidence so far. The first was seen in the Introduction, in which the nature of the doctor patient relationship is judicially determined. That determination forms a cornerstone on which to build the nature of the duty of care in any negligence action. The simple act of holding that a duty of care exists allows the case to proceed to the next element of proof. To hold otherwise would render the matter stillborn.[81]

The second step involves the use of the delict or tort of negligence which ensures that the burden of proof remains on the pursuer[82] - as opposed to using the torts of assault and battery, the criminal law or breach of a fiduciary relationship. This ensures that there is some equilibrium maintained and that the court has many opportunities in the legal process to keep its finger on the pulse and to influence the direction of the case through the acceptance or rejection of expert evidence.[83] Judicial determination and weighting of evidence in terms of its persuasiveness is a policy-guided activity and places the court as arbiter in a very powerful though unenviable position to mediate between parties' interests and to determine outcomes on the basis of precedence, policy and persuasion.

The third step might be described as the insurance policy which insures the policy-making power of the court. This step comprises the court setting itself up as arbiter in a move

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[79] This will be more fully discussed in Chapter 4.
[80] 247, citing *Sidaway* [1984] 1 All ER 1018, 1026 and *Chatterton v Gerson* [1981] 1 QB 432 per Bristow J.
[81] As happened in a case in which it was held that no duty of care was owed by a doctor to a job applicant. See Clare Dyer, 'Doctor owed no duty of care to job applicant', *British Medical Journal* 1998; 316: 1037 (4 April).
[82] With the possible exception of instances in which *res ipsa loquitur* is applicable.
[83] Cf. Chapter 6.

which will serve to insulate the other, chronologically appearing, policy moves which will be encountered in subsequent chapters. The court as arbiter of medical and lay evidence will emerge as particularly important in respect of British jurisdictions.[84] The next obviously policy-guided step, for example, is the court's decision on whether a duty of care exists in the circumstances of a particular case and indeed what standard should be achieved by the exercise of that duty.

[84] Cf. Chapters 5 & 6.

CHAPTER 3

THE CONSENSUAL PATIENT

3.1 DUTY AND INFORMATION: INFORMED CONSENT DOCTRINE

3.1.1. CONTEXT

Once it is established that a duty of care both exists and encompasses the provision to the patient of information on risks and alternatives to the proposed treatment, the question before the court is *how much and what sort of information is required?* This is a question of the *scope* of the duty of care. The last chapter touched on the matter of the standard of care as an important device in the limiting of liability. This chapter will discuss judicial *tests* for the standard of that care.

It is clear at this stage that the doctor-patient relationship gives rise to a duty of care and that injury allegedly attributable to lack of information is argued in negligence.[1] Disclosure cases have to do with the communication of information and, hence, whether that information was material to the decision of a plaintiff-patient to undergo treatment. How courts define and apply tests for *materiality* is pivotal to the inquiry and dovetails with the inquiry into legal causation.[2] As in the previous chapter, one might begin with Canada, while at the same time bearing in mind that it is the exception that proves the rule that 'proximity' is a limiting device in the law of torts.[3]

The doctor-patient relationship is considered fiduciary in Canada. This casts the scope of information required in terms of trust or confidence; it is a matter of particular concern when

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[1] With the exception of South Africa where the *volenti* defence removes the matter from the confines of negligence (even though judgement will ultimately be expressed in negligence terms). This is discussed in the current chapter as well as in Chapter 4 on Causation.

[2] This is because the *sine qua non* test for legal causation has to do with the perception - of patient or practitioner - of the materiality of the risk which eventuated and caused injury.

[3] Canadian courts still use proximity, but consider the proximity between doctor and patient to give rise to a fiduciary duty.

the relationship between the parties has the potential for undue influence.[4] Because of the expertise and superior knowledge of the medical practitioner, such a relationship was held to exist between doctor and patient in *Arndt v Smith.*[5] Lambert JA categorised informed consent cases as those based on a fiduciary relationship between doctor and patient. He drew on *Halushka v University of Saskatchewan*[6] and *Kenny v Lockwood* [7] to make that assertion. He went on to draw the conclusion that,

> ' ... the duty of disclosure of material risks or of special or unusual risks is not like an ordinary duty of care in negligence, because it is not set by the standard of a reasonable medical practitioner, but is more similar to a fiduciary duty of disclosure, where the standard is set by utmost good faith in the discharge of an obligation by a person in the position of power and control to a person who is vulnerable, in a position of dependency, and is known by the doctor to be in a position of reliance.' [8]

This judgement placed the informed consent scenario in the context of power and information - power over information and communication of information. It also elaborated upon the policy device of 'proximity'.

In *Reibl v Hughes* the Supreme Court of Canada had noted that, 'the relationship between surgeon an patient gives rise to a duty of the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery that is recommended.'[9] The court based its rationale on proximity without needing to specify the constitution of that proximity.

Arndt v Smith presented a new gloss on the informed consent issue because the vast majority of cases being considered here, including those which were heard in Canada before *Arndt v Smith*, were argued as 'proximity' cases. As such it is deemed by the law of torts that the relationship between doctor and patient is sufficiently proximate to found a duty of care of a raised standard. The question before the courts concerns the precise content of the duty of care in respect of information disclosure.

The Australian courts, on the other hand, have considered the relationship not as

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[4] Such as mother and daughter in *Lanarkshire Loans Ltd v Black* [1934]1 KB 380, or a member of a religious order and their superior in *Allcard v Skinner* (1887) 36 Ch D 145.
[5] [1996] 7 Med LR 108, 113-114.
[6] [1965] 53 DLR (2d) 436.
[7] [1932] 1 DLR 507 (Ont. CJ).
[8] *Arndt v Smith* [1995] 7 Med LR 108, 113.
[9] *Reibl v Hughes* (1980) 114 DLR (3d) 1, 5.

fiduciary, but rather as proximate enough to found a duty of care.[10] In *Rogers v Whitaker* Mason CJ said, 'The law imposes on a medical practitioner a duty to exercise reasonable skill and care in the provision of professional advice and treatment.'[11] The court in Australia considered the fiduciary relationship in relation to the scope of the duty of care in *Hospital Products Ltd v United States Surgical Corporation*:[12] Mason J, as he then was, said, 'it is now acknowledged generally that the scope of the fiduciary duty must be moulded according to the nature of the relationship and the facts of the case.'

3.1.2. CONTENT

A patient's consent to a procedure is necessary for the medical practitioner's actions to be legal, but different jurisdictions interpret the so-called 'transatlantic doctrine of informed consent' differently. As describing the standard of care, the doctrine has been held in cases such as *Rogers v Whitaker* in Australia[13] and *Sidaway v Bethlem Royal Hospital* in England[14] to be meaningless or at least inapplicable. At the same time the term is used by courts to uphold the ethical principle of self-determination which underlies the legal principle of consent to medical treatment. The doctrine came from America and has been accepted to a degree in South Africa, Canada and Australia, though not in either England or Scotland.

At the outset it must be stressed that the doctrine of informed consent is an American jurisprudential concept. Thus, while other jurisdictions may not adopt it *per se*, they may adapt it or indeed reject it. Even so, rejection of the doctrine does not in itself mean that courts in a particular jurisdiction are abandoning the consent principles embodied by the doctrine; it does not mean that there is, therefore, no judicial policy on matters of medical negligence which are based on information and consent. What can be said is that those jurisdictions which accept the doctrine may be said to have adopted a policy favourable to the patient while others tend to favour the medical practitioner.

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[10] *Breen v Williams* [1995] Med LR 385.
[11] *Rogers v Whitaker* [1994] 4 Med LR 79, 80.
[12] (1984) 156 CLR 41, 73 per Gibbs CJ, and 102.
[13] *Rogers v Whitaker* (1992)109 ALR 625, 633, [1993] 4 Med LR 79, 83 in which Mason, CJ said that 'nothing is to be gained by reiterating... the oft-used and somewhat amorphous phrase "informed consent".' Objection was to the terms or doctrine rather than to its principles, which were adopted in this case.
[14] *Sidaway v Board of Governors of the Bethlem Royal Hospital and others* [1984]1 QB 493 [1984] 1 1018 CA, [1985] AC 871, [1985] 2 WLR 480 (HL), [1985] 1 All ER 643.

This position is in flux insofar as one can detect in medical practice a move away from the prior, tacit or general consent described by Classic Liberalism to a more specific consent for each procedure as part of a duty of information.[15] Indeed, Lord Caplan said in *Moyes v Lothian Health Board*,[16]

> 'The risks inherent in a particular operation or procedure, the manner in which the operation may affect or damage a particular patient, the medical need for the operation and the ability of the patient to absorb information about his situation without adding damage to his health, are all matters where the doctor, with his own clinical experience and the benefit of the experience of other practitioners, is best able to form a judgement as to what the patient can safely be told in the exercise of medical care.'

Consent to medical interventions entails a voluntary decision made by a competent person on the basis of adequate information. The question of adequacy of information given is moot in any jurisdiction and has to do with what sort of test is used by the court as well as with the court's definition of materiality.[17] If consent cannot be completely valid in the absence of information which is adequate to found understanding on the part of the patient,[18] then the term 'informed consent' would appear redundant or self-justifying. The rationale here is that while consent will remain compulsory for medical procedures, it cannot be true consent if it is not informed.[19] This rationale is less apposite when one considers that informed consent is a doctrine rather than merely a descriptive tautology.

This duty to inform is subject to certain exceptions[20] such as 'necessity',[21] which is always open to the practitioner and is assessed in England and Wales according to the *Bolam*

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[15] This is in part due to the increasing complexity of medical procedures.
[16] 1990 SLT 444, 449J-K.
[17] See 3.3. below.
[18] Other forms of consent are possible, such as implied, tacit or prior-general consent. Implied consent, too, requires full prior knowledge and covers circumstances of 'necessity'. See Syvil Lloyd-Morris, 'The Age of Consent' (1991)141 *New Law Journal* 426.
[19] With the exception of children and the mentally incompetent; categories excluded from this thesis.
[20] Examples are emergency, the only course open (to which the patient could answer that he or she would have wanted a second opinion), or that there is no chance of harm (this is unlikely to be the case factually but a practitioner should be obliged either to refer the patient for a second opinion or simply to say that there is no risk).
[21] Generally, the requirements for a defence of necessity to succeed are that the patient is unconscious, has not previously expressed any objection to the form of treatment proposed and that what is done could not reasonably be delayed.

test and in Scotland according to *Hunter v Hanley*[22] - tests which favour the practices of the medical profession over the desires of the patient. Although the point was not argued in *Hunter*, it is also subject to 'therapeutic privilege'.[23]

The test for necessity needs to be objective and based on the standards of the medical community because it is only that community which can answer the question of necessity as a matter of medical fact.[24] Naturally, the spectre of defensive medicine raises its head at this point insofar as doctors would at times rather leave a patient untreated than treat that patient at the risk of litigation in which the only available defence might be that of necessity.

In *Re T*,[25] Lord Donaldson stated that 'the law requires that an adult patient who is mentally and physically capable of exercising a choice must consent if medical treatment of him is to be lawful.' Possibilities such as tortious liability are excluded as a result of a valid consent having been given. The two component parts of the informed consent issue were succinctly stated by Hoyt JA in the Canadian case of *Kueper v McMullin*:[26] was the risk one which ought to have been disclosed to the patient and, if so, would a reasonable person, after having been fully informed of the risk, have consented to the procedure? These questions relate to the materiality of the information to the patient and to legal causation. [27]

In *Daniels v Burfield* [28] in Australia, the plaintiff alleged that prior to the operation the defendant 'failed to obtain the plaintiff's informed consent to it'. The plaintiff's plea was that he would not have had surgery had he been informed of the risk involved. However, he failed to

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[22] Cf. 3.2.

[23] This is used as a counter-argument in cases in which failure to disclose is alleged, but it is constantly eroded by the courts because it was not designed to be raised after the event or during litigation to excuse an oversight. Rather, its purpose is to excuse the practitioner in cases where, objectively assessed, disclosure would have been deleterious to the emotional state of the patient. It has been argued that a medical practitioner has a right of non-disclosure vis-à-vis the patient which is based on the amount of knowledge and understanding about the general nature of the procedure which the patient is capable of gaining. Accordingly, doctors need not warn of everyday risks attendant to surgical procedures (at the one end of the scale) or (at the other) of procedures which the particular patient is incapable of understanding. This is also tested objectively in Canada: see Dickens B M *Justice Beyond Orwell*. 1985. Les Editions Yvon Blais Inc. Montreal. 259.

[24] This means that at this stage of the inquiry, all jurisdictions effectively adopt a *Bolam* style test for necessity.

[25] *(adult)(refusal of treatment)* [1992] 4 Med LR 649, [1992] 3 Med LR 306.

[26] (1987) 30 DLR (4th) 408, 412.

[27] This depends on the type of testing used. The first question depends on the court's standards on disclosure, the scope of the duty of care and on the test for materiality (See 3.3. below). The second question concerns causation (see Chapter 4).

[28] AUST SASC 1769.

discharge the burden of proof of causation and his claim accordingly failed. Similarly, in *Kitchen v McMullin*[29] in Canada, the trial judge concluded that in this case even if the risk were to have been disclosed, the plaintiff would still have given his consent because surgery was necessary.

3.1.3. THE STANDARD OF CARE WITHIN THE COMMONWEALTH

The standard of the legal duty of care vis-à-vis information in the United Kingdom is based almost exclusively on medical opinion. It has been rejected in Canada, Australia and South Africa and is in flux in the United Kingdom. [30]

Because informed consent criteria are imposed by the courts rather than by the professional community, this imposition is often seen as an attack on doctors. Yet in the United Kingdom the medical profession imposes these criteria on itself in the form of guidelines and advice from professional associations other than the GMC.[31] One of the far-reaching implications for the autonomy of the medical profession is that health authorities can be subject to judicial review and sanction with respect to the quality of doctor-patient communication.[32]

Commonwealth jurisdictions define informed consent the same way in which it was defined in America.[33] In *Reibl v Hughes* in Canada, Laskin CJC discussed the doctrine in terms of liability for battery or in negligence, quoting the trial judge as saying that,

> 'the issue of "informed consent" can arise in both battery and negligence cases: with respect to the former a lack of proper information communicated by the doctor to the patient can vitiate an apparent consent, while with respect to the latter, failure to see that the patient is properly advised can amount ... to an act of negligence.'[34]

Laskin CJC went on to draw on *Scloendorff v Society of New York Hospital*[35] and on *Canterbury*

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[29] (1990) 62 DLR (4th) 481, 490.
[30] In *Sidaway*, only Lord Diplock accepted the *Bolam* principle without modification. All the other Law Lords, while accepting it in principle, preferred a more patient-oriented test. See Chapter 6 on the *Bolam* standard (particularly 6.3.2).
[31] Issued by medical protection organisations and statutory bodies.
[32] Kaufmann, Caroline L. 'Informed Consent and Patient Decision Making: Two Decades of Research' (1983) 17:21 *Soc. Sci. Med.* 1657-64, 1661.
[33] Differences among jurisdictions emerge when it comes to the doctrine's application and adoption and particularly the test for legal causation (Ch.4).
[34] *Reibl v Hughes* 9.
[35] Ibid., 10.

v Spence[36] so defining the doctrine as he used it.

Canterbury v Spence and *Reibl v Hughes* were both distinguished in *Sidaway*. Lord Scarman noted that the appellant was 'in effect [invoking] the transatlantic doctrine of informed consent',[37] later noting that '[i]n Canada, in *Reibl v Hughes* ... Laskin CJC expressed broad approval of the doctrine of informed consent as enunciated in *Canterbury v Spence* ... though it would seem that approval of the doctrine was not necessary to a decision in that case.'[38] More to the point, Lord Diplock said,

> 'The juristic basis of the proposed situation which originates in certain state court jurisdictions in the United States of America and has found some favour in modified form by the Supreme Court of Canada appears to me, with great respect, to be contrary to English law. Its foundation is the doctrine of "informed consent" which was *originally* based on the assumption ... in *Canterbury v Spence*.'[39]

In Australia in *Rogers v Whitaker*[40] the court considered *Reibl v Hughes* and *Canterbury v* Spence; indeed Mason CJ noted that Lord Scarman had referred to the latter case in *Sidaway*.[41] Similarly, in South Africa in *Castell v DeGreef*[42] at first instance Scott J, drawing on *Reibl v Hughes* and *Canterbury v Spence* said, '[Counsel for the plaintiff] invites me to adopt, if not in its entirety, certain aspects of "informed consent".' However, he went on to note that '[t]he House of Lords in the *Sidaway* case (Lord Scarman dissenting) declined to adopt the doctrine and instead reaffirmed the "*Bolam*" test. In my view there can be no justification for adopting it in our law.'[43]

Gradual acceptance of the doctrine in parts of the Commonwealth has latterly ushered in a greater demand for the patient's *understanding*. The principle of negligence based on lack of

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[36] Ibid., 14.
[37] *Sidaway* [1985] 1 AC 871, 883.
[38] Ibid., 887.
[39] Ibid., 894. Emphasis added. In support, Lord Bridge said (at 898), '... the decision mainly relied on to establish a criterion of the doctor's duty to disclose the risks inherent in a proposed treatment which is prescribed by the law and can be applied independently of any medical opinion or practice is that of ... *Canterbury v Spence*.'
[40] (1992)109 ALR 625, 633, [1993] 4 Med LR 79.
[41] [1993] 4 Med LR 79, 82.
[42] (1993) 3 SA 501, 518.
[43] This was, however, prior to Ackerman J's Appeal decision which overturned this part the decision of Scott J in the court *a quo* and adapted the doctrine to the needs of South African law. Cf. 3.2.2.3. & 6.4.3.

an informed consent is that true consent depends on an understood[44] choice on the part of the patient. The effect is to move away from the ambit of assault and to extend negligence principles to include situations in which due care was exercised in the clinical procedure adopted, but in which a medically acknowledged risk of harm eventuated. A plaintiff would succeed in a negligence action by proving that the duty of care demanded the provision of information on a particular risk, and that he would not have undergone the treatment which harmed him had he known of and understood that risk.

The standard of the medical profession vis-à-vis the duty of information has been rejected in Canada, as well as in Australia where 'the High Court of Australia clearly and explicitly chose the patient-oriented "American" rule ...'.[45] The medical professional standard is gradually able to support the plaintiff's case in England[46] yet the doctrine continues to expand in America and evolve in the Commonwealth in favour of the prudent or subjective patient. McLean[47] and Mason & McCall Smith[48] doubt that the prudent patient test will come to the United Kingdom 'in the foreseeable future', even though expansion still appears to be in that general direction in England. This thesis argues in favour of the opposing position. If a patient is to be warned of 'material risks', at this stage of the judicial inquiry matters boil down to what sort of test is adopted for 'materiality'.

3.2. DIFFERENCES BETWEEN BRITAIN AND OTHER JURISDICTIONS

It has already been stated that Courts in Britain use the tests set out in *Bolam* and in *Hunter v Hanley*. The *Bolam* principle, as outlined with approval in *Sidaway,* 'may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice adopted at the time as proper by a responsible body of respectable medical opinion'.[49] In *Sidaway*,[50] Lord Diplock noted,

> 'The *Bolam* test is far from new, its value is that it brings up to date and re-expresses in the light of modern conditions in which the art of modern medicine is now practiced, an ancient rule of common law. The original rule can be traced to the maxim *spondet*

[44] See *Lybert v Warrington Health Authority* [1996] 7 Med LR 71 CA.
[45] Don Chalmers & Robert Schwartz '*Rogers v Whitaker* and Informed Consent in Australia: a Fair Dinkum Duty of Disclosure.' (1993) 1 *Medical Law Review* 139, 144-45.
[46] Cf. 3.3.4., 5.4.4. & 6.3.
[47] McLean, Sheila A M *A Patient's Right to Know: Information Disclosure, the Doctor and the Law*. 1989.
[48] Mason & McCall Smith *Law and Medical Ethics (4ed)* 246-247.
[49] McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 586-7.
[50] [1985] 1 AC 871, 892.

> *peritiam artis et imperitia culpae admuneratur.* It goes back to the origin of assumpsit; it applied to all artificers and was firmly founded in "case" (moderniter negligence) although it may be of interest to note that as long ago as 1767 in *Slater v. Baker*, 2 Wils. 359, a suggestion that where the injury was caused by surgery the form of action lay in trespass vi et armis was rejected with scant sympathy by the Court of King's Bench.'[51]

The original *Bolam* test is different in a subtle but important way from that set out in Scotland in *Hunter v Hanley*. It is worth reiterating that in that case Lord President Clyde said,

> 'To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice. Secondly it must be proved that the defender has not adopted that practice, and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which *no professional man of ordinary skill* would have taken if he had been acting with ordinary care ...'.[52]

The crucial difference lies in the emphasised portion of this quotation.[53] In England in order to escape liability in negligence, it must be established that a responsible body of medical practitioners would have adopted the practice actually adopted. On the face of it the test in Scotland is a stricter one which favours the practitioner more than the English test favours the practitioner. To prove liability in negligence, it must be established that *no* practitioner of ordinary skill would have adopted the procedure actually adopted.

Again on the face of it, the Scottish test remained unchanged in *Moyes v Lothian Health Board* in which Lord Caplan argued that the confirmation of the *Bolam* test in *Sidaway* did not alter the test in *Hunter v Hanley*. This said, there seemed to be a coming-together of the two jurisdictions in *Moyes* in which Lord Caplan considered, with approval, the judgement of Lord Bridge *Sidaway*:

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[51] That the court is able to trace the *Bolam* principle back to the maxim *spondet peritiam artis et imperitia culpae admuneratur* ('he is responsible for skill in his profession and want of such skill is regarded as a fault') suggests a combination of skilful performance and disclosure requirements - a combination which is denied. But the essential ethical and policy point concerns *reliance*. The patient is entitled to be able to rely on the doctor. The question remains: in defining the scope of the doctor's duty of care, does the patient not expect that he will have been warned of all material risks? Having defined what is expected, the doctor will be liable for any deficiency in living up to expectations. This is why this definition of the scope of the duty of care is the central ethical consideration in any negligence action based on consent and why this inquiry can be included under the 'policy' head.

[52] *Hunter v Hanley* 1955 SLT 213, 217; emphasis added. This important quote is being reiterated here for the sake of clarity and relevance.

[53] This point is made in a contributed article, '*Hunter v Hanley* 35 Years On' 1990 *Scots Law Times* 325. Cf. 6.3.1 in which it will be argued that the *effect* of these linguistically different tests is virtually the same. Indeed, that is a stance argued in a response to the above article and on the basis of *Moyes v Lothian Health Board* and *Goorkani v Tayside Health Board*: Dermot K. Feenan 'Medical Negligence: *Hunter v Hanley* 35 years on: a reply' 1991 *Scots Law Times* 321.

> 'My understanding is that in Sidaway, Lord Bridge did not dispute that in questions of medical practice where the skill or the knowledge, or specialist experience of the doctor is the material factor, standards will be regulated by the standards of responsible members of the profession. However the issue of what properly falls within the ambit of medical expertise should not be regarded too narrowly since, for example, the doctor's skill in handling his patients may be as much a product of his clinical experience as diagnosis or the prescription of medicine.'[54]

This was confirmed in *Gordon v Wilson*[55] in which Lord Penrose endorsed medical paternalism saying: 'In my opinion nothing in the speech of Lord Bridge was intended to qualify the *Bolam* test. That was the view taken by Lord Caplan in *Moyes* ... and I respectfully agree with his comments.' However, Lord Penrose acknowledged that the test was that set out in *Hunter* and the *Bolam* test was (merely) helpful rather than decisive. It remains the case that Scottish Courts are even more reluctant to hold practitioners liable than are their English counterparts.[56] As for the test, since *Moyes* it has been accepted that the two tests are equivalent to one another. It is the test of reasonable proficiency as assessed by the defender's peers.

The requisite reasonable[57] proficiency is variable according to circumstances and commensurate with the standing professed. It is applicable only once the doctor-patient relationship[58] has been established because there is no negligence without a duty of care and breach of this duty of care involves failure to reach that standard. Lord Fraser, in *Whitehouse v Jordan*, expressed the position in the following way:

> 'The true position is that an error of judgement may or may not be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having, and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligence.'[59]

The standard of care is expressed in *Bolam* in England and in *Hunter v Hanley* in Scotland. This

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[54] Ibid., 450.
[55] 1992 SLT 849. 852.
[56] This argument is based on the fact that fewer Scottish informed consent cases are won by pursuers than those which are won by plaintiffs. It is acknowledged, however, that this may have to do with the fact that the jurisdictions are different in size and the fact that a case being won depends on such a case coming to the attention of the courts, that is of injury occurring which is the alleged result of an uninformed consent. Cf. 6.3. & 6.4.
[57] Which is often synonymous with 'responsible' in the case law.
[58] Comprising a willingness to examine, diagnose and treat on the part of the doctor and to be examined and treated on the basis of that diagnosis on the part of the patient.
[59] [1980] 1 All ER 650, 659.

standard amounts to peer-assessment in British courts. In the Commonwealth different tests are used in different jurisdictions according to the extent to which the court accepts a medical professional standard. British acceptance of that standard means that in order to determine what constitutes proper treatment, the court consults the medical profession as represented by expert witnesses.[60]

3.2.1. TWO BRITISH TESTS?

The salient point about a legal test for the validity of consent is whether any decision regarding treatment has been based on adequate information; it is about the legal test for the adequacy of information given. In England and Scotland, judiciaries view materiality from the perspective of the reasonable doctor rather than the reasonable patient in the actual patient's position. The relevant question is 'what can the doctor be expected to have disclosed to this patient?' To answer this question, courts in England apply the *Bolam* test and in Scotland courts apply *Hunter v Hanley*. Either way the matter is one of judicial policy and the extent to which it favours the doctor's opinion over the patient's rights.[61]

3.2.1.1. ENGLAND

The *Sidaway* case concerned a patient who was not told of a chance of about one per cent that paralysis might result from an operation on her neck. That chance eventuated. The House of Lords confirmed the *Bolam* test with regard to disclosure of inherent risks. It did, however, rule that medical opinion was not decisive and retained the right to overrule it if disclosure was 'obviously necessary' to an informed decision by the patient.[62] Lord Bridge considered that circumstances could arise where the court might reject the standard of accepted medical practice, indicating a possible flexibility in the *Bolam* standard.[63] Lord Templeman agreed and said that the court would determine whether the doctor had 'blundered' in not disclosing information. The central issue here concerns the weight given by the court to the medical evidence of each side, and indeed the *fact* that the court weighs up evidence from both sides.[64]

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[60] Cf. Chapter 5.
[61] See M Robertson 'Informed Consent to Medical Treatment' (1981) 97 *LQR* 102 in which the author appreciated this point in the very early days of acceptance of the doctrine in the Commonwealth.
[62] [1985] 1 All ER 643 (HL), 663.
[63] Cf. Chapter 6, particularly 6.3.
[64] Although it may not prefer one body of respectable opinion over another. Cf. Ch. 5 on the expert witness.

Lord Scarman, dissenting in *Sidaway* after considering *Canterbury v Spence* and *Reibl v Hughes,* would have found the doctrine of informed consent to be the law in England.[65] The majority of the bench in *Sidaway*, however, adopted a paternalistic approach oriented towards the medical practitioner and aligned informed consent with professional duty. Yet it did not leave the issue in the hands of the medical profession alone. *Bolam,* it should be noted, was a decision of first instance and what has become the *Bolam* test was part of a judicial summing-up presented to the jury.[66] It was supported by the House in *Sidaway*, even though their Lordships were divided on its adequacy.[67] Lord Scarman, however, expressed the view that the *Bolam* test constitutes a dilution of patient autonomy, which is the very basis of the principle of consent.

According to Balen, [68] a doctor 'needs to ask the question 'is the "level of capacity demonstrated by the patient commensurate with the gravity of the decision to be taken in giving or refusing consent?".' Only if the answer is 'no' should paternalistic principles be invoked; yet the problem will remain that the *Bolam* standard is still employed in assessing the *capacity of the patient to understand.*[69]

According to the Canadian Law Reform Commission, on the other hand, the test for comprehension should be apparent-subjective, with the onus on the practitioner to take reasonable steps with regard to the particular patient to ensure understanding. Paternalism in the

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[65] *Sidaway v Bethlem Royal Hospital Governers* [1984] AC 871, 885. He said, '[M]y Lords, I think the *Canterbury* propositions reflect a legal truth which too much judicial reliance on medical judgement tends to obscure. In a medical negligence case where the issue is the advice and information given to the patient as to the treatment proposed, the available options and the risk, the court is concerned primarily with a patient's rights. The doctor's duty arises from his patient's rights.' However, Teff (*Reasonable Care: legal perspectives on the Doctor-Patient Relationship.* 1994. Oxford University Press. Oxford) at 103 considers and criticises this rights-based dissent by saying that with medicine considered as trade the effect is to breed medical relations in which 'rights' rather than 'duties' becomes the 'appropriate form of moral discourse'. This places legal and medical discourses at loggerheads. 6.3.1.2. will consider this position more fully and in the light of the *European Convention on Human Rights and Biomedicine*.

[66] It was, however, confirmed and applied (and hence elevated) by the Privy Council in *Chin Keouw* [1967] 1 WLR 813, in the context of an omission to enquire of a patient about allergy to penicillin.

[67] Even though *Bolam* was supported, it was watered down, in *Sidaway*. *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 634 HL accepted this as watered-down support.

[68] In *having* to 'ask the right questions' in English law, the onus of inquiry is placed on the patient and the obligation is raised only in the case of the inquisitive patient. See Balen, P. 'Consent to Medical Treatment' (1994) 138 *Solicitors Journal* 121-123, 121.

[69] The test for competency, too, is from the point of view of the medical practitioner in British Jurisdictions and from the patient's point of view elsewhere. Consider, in this light, the *Grannum* test for competency in America in 1.1.4. and the consideration of the contractual *context* of the doctor-patient relationship in 3.4.2.

form of the *Bolam* test is, however, under increasing pressure in England. Miller[70] noted that in 1988 the British Medical Association, too, had changed its emphasis in doctor-patient relations from paternalism to partnership. There is further evidence in the National Health Service *Patients' Charter* of 1992,[71] which states that every citizen has the *right* 'to be given a clear explanation of any treatment proposed, including *any* risks and alternatives.'[72]

In *Gold v Haringey Health Authority*[73] the English Appeal Court overturned the decision of court of first instance and held that the *Bolam* test applied not only to the medical arena but to any raised standard or professional duty of care in which special skill has been professed.[74] This professional standard also applies in Scotland.

3.2.1.2. SCOTLAND

In *Moyes v Lothian Health Board*[75] the Court of Session held that it was not the law that the informed consent of a patient had in all circumstances to be obtained. Similarly, in *Gordon v Wilson & others*,[76] the Court of Session considered *Sidaway* and *Moyes* and attached particular weight to the judgement of Lord Bridge in *Sidaway*. His Lordship was responding to comments of Laskin CJC in *Reibl v Hughes* in which the latter distinguished the informed consent case from cases involving the question whether the doctor had carried out his professional activities by applicable professional standards. This distinction was accepted by Lord Bridge yet the same standard, the *Bolam* standard, was held applicable in both scenarios (as was the case in *Gold*). The judgements in *Gordon v Wilson* and *Moyes v Lothian Health Board* indicate that Scottish courts do not truly acknowledge that distinction and see the practitioner's duty (in *Hunter* and in *Bolam*) as defined by a single test.

Common practice still plays its most conspicuous role in actions based on alleged

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[70] Frances H Miller 'Denial of Health Care and Informed Consent in English and American Law' (1992) 18 *American Journal of Law and Medicine* 37.
[71] Miller 69.
[72] *The Patients' Charter* 1992, 9; emphasis added. This is supported by M Dean *The Lancet* 341 (April 1993) 883 (quoted by Balen at 121) as well as by the Medical Defence Union in the United Kingdom.
[73] [1988] QB 481, [1987] 2 All ER 888, 894.
[74] An apposite point which this thesis will go on to make is that this standard applies to treatment and to information in the UK, whereas elsewhere in the Commonwealth, different standards are applied to these different aspects of medical practice.
[75] 1990 SLT 444, 449; [1990] 1 Med LR 463, 469 per Lord Caplan.
[76] 1992 SLT (NOTES) 849.

medical negligence.[77] The Court of Session in *Moyes* considered practices varying between practitioners and affirmed that a failure to warn of risks was always to be judged by practitioners' standards, which is increasingly being seen as inappropriate by other jurisdictions.

Because as a general rule the judiciary lacks medical expertise, it is possible for a plaintiff to make good use of the *Bolam* test only in respect of the standards of disclosure of inherent risks which is required by the law. This is because materiality of information can be assessed in lay terms, while negligence *simpliciter* can not. In *Sidaway* and *Gold* it was held that the standards applicable to diagnosis and treatment should be the same as those applied to disclosure,[78] with the court remaining the arbiter on the matter.[79] What emerges is an isolation of the duty of information from treatment standards and it is at the point of the duty of information at which the *Bolam* standard is proving useful to the plaintiff in both England[80] and Scotland.[81]

3.2.2. THREE COMMONWEALTH TESTS

Once a jurisdiction has accepted informed consent as describing the standard of care in cases which involve information on risks and alternatives, the only remaining moot point is that of causation. The exception here is the case of South Africa, in which the doctrine was neither accepted nor rejected, but adapted to fall in line with *volenti non fit iniuria* as a mechanism of describing the duty of information.

There are two possible standards which can be adopted which represent different interests: a medical standard is accepted to a degree in the United Kingdom, but a more patient-centric standard is adopted elsewhere in the Commonwealth. Such a standard may be either subjective or more objective.

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[77] Cf. *E v Australian Red Cross Society* (1991) 99 ALR 601, 650, [1991] 2 Med LR 303, 329.
[78] [1984] QB 493, 511 *et seq.*, [1984] 1 All ER 1018, 1026 *et seq.*
[79] In *Rogers v Whitaker* and *Reibl v Hughes,* however, a difference between information and treatment was acknowledged: *Rogers v Whitaker* (1992) 109 ALR 625, 632, quoting *Reibl v Hughes.*
[80] Cf. *McAllister v Lewisham* [1994] 5 Med LR 343, *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334 and *Newell and Newell v Goldenberg* [1995] 6 Med LR 371 which will be discussed in Chapter 6 (6.2.). See also Kennedy and Grubb 'The New Bolam', *Medical Law Review* Vol. 3 No. 2 p 197. This will be considered more fully in 6.3.
[81] *Goorkani v Tayside Health Board* [1991] 3 Med LR 33

The subjective test has been criticised for being enslaved by the hindsight of the unreasonable patient and on the basis that it would not be practical to handle all patients identically and with a view to fairness. A more objective test, on the other hand, dispenses with the problem of hindsight by asking how the average prudent person in the plaintiff's situation would have decided in the given circumstances. It also dispenses with the problem of holding a practitioner liable for the 'whimsical' courses of action of his patients under a more subjective test. The plaintiff's apparent desire for knowledge comes into play only as indicative of what the physician ought objectively to have known of the patient's information needs. Although called objective, it remains a test taken from the patient's point of view. Objectivity is injected by considering the prudent patient rather than the particular or subjective patient assessed.

3.2.2.1. CANADA

What the reasonable patient in the particular patient's position would want to know forms the basis of the test as set out in Canada in *Reibl v Hughes.*[82] It was held that the court or the jury may assess this. This is the case in which the doctrine was adopted. It concerned the surgeon's failure to warn of a ten per cent risk of a procedure resulting in a stroke. There the court formulated the apparent-subjective test for materiality, which was different from the test used where negligent performance of the surgical procedure itself is alleged (negligence *simpliciter*). The Court held, 'The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the physician's recommendation'.[83]

Later, in *White v Turner,*[84] the Ontario High Court of Justice extended *Reibl v Hughes* to some degree in holding not only that material risks as well as unusual risks should be disclosed, but that there is an overlap between these two categories. With the advantage of hindsight it would be easier for a plaintiff to assert that he would not have undergone a certain procedure.

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[82] (1980) 114 DLR (3d) 1

[83] *Reibl v Hughes*, 16. Laskin CJC formulated a modified objective test for causation to be applied in informed consent cases, saying, 'the adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it if proper disclosure had been made of the risks attendant upon it, balanced by those against it'. This means that negligence may be established, but that does not mean that liability – and hence damages – follows. See Chapter 4 on Causation.

[84] (1981) l20 DLR (3d) 269.

For this reason, the Canadian decision in *Hopp v Lepp*[85] asserted that the issue is whether the reasonable person in the plaintiff's position would have declined or accepted treatment given the information available at the time and excluding the advantage of hindsight. This modified objective test for causation injects objectivity into the plaintiff's assertions on materiality and causation and the result disposes of the case.

This 'apparent subjective' or 'modified objective' standard was confirmed in *White v Turner*[86] according to which the court has to be satisfied regarding what the reasonable patient in the same situation would have done or wanted. In *Haughain v Paine*[87] it was held that in order to enable a patient to give informed consent to surgery, in addition to disclosing the material risks of the surgery, a surgeon must also explain to the patient the consequences of leaving the ailment untreated as well as the alternative means of treatment and their risks. This is the test for the standard of care. The process is subtly different in Australia where the test applied to the patient is a subjective one, which is then turned into an objective expectation of the surgeon.

3.2.2.2. AUSTRALIA

Although a *Bolam* style test had traditionally been employed in Australia,[88] the decision in *Rogers v Whitaker* demonstrated a move towards more objective testing of the informed consent issue.[89] The case turned on whether the amount of information the doctor had disclosed complied with the standard of care which could reasonably be expected of him. The court held that notification should have been given of a one in 14,000 risk of the patient developing sympathetic ophthalmia during eye surgery.

Significantly, the defence relied on *Bolam* but the court, like its Canadian counterpart, rejected that submission by distinguishing information from treatment.[90] The court in *Rogers v Whitaker* held that evidence of acceptable medical practice serves as merely a useful guide to the courts, whose prerogative it remains to determine the appropriate standard of care, particularly

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[85] (1981) 112 DLR (3d) 67, which was supported in *Reibl v Hughes* (1981) 114 DLR (3d) 1 (in fact Laskin CJC was on the bench in both cases) and advanced an objective disclosure test.
[86] (1981)120 DLR (3d) 269, 283 *et seq.*
[87] (1987) 37 DLR (4th) 624.
[88] Australian courts had adopted the subjective approach in *Ellis v Wallsend District Hospital* [1990] 2 Med LR 103, *H v Royal Alexandra Hospital* [1990] 1 Med LR 297 and *F v R* (1983) 33 SASR 189.
[89] That is the issue of the scope of the duty of care rather than the issue of the test for causation.
[90] Cf. Discussion of *Reibl v Hughes* in 3.2.2.1.

with regard to disclosure of information.

There the plaintiff successfully argued that the *Bolam* principle should not be applied because it involves deferring to medical experts in medical negligence cases.[91] Counsel for the plaintiff also argued successfully that the primary judge was correct in not deferring to the views of those medical practitioners who gave evidence that they would not have warned the plaintiff. The *Bolam* standard, then, is prone to displacement wherever courts assert their own primacy over medical practice, in the context of advice and information given to patients.[92]

Account is to be taken of the particular patient's position; this is then translated into an objective requirement of the doctor. If, for example, the patient indicates a clear concern of a certain nature and a general inquisitiveness (as occurred in *Rogers v Whitaker*), the reasonable medical practitioner could then be expected to know that she would want to be informed of any such related risk. In this instance, it was held that because Mrs Whitaker had shown a general concern regarding damage to her 'good' eye[93] during surgery, the reasonable eye surgeon ought to have appreciated that this particular patient would want to be warned of the risks[94] of damage to that eye and that one such risk was that of sympathetic ophthalmia.

Under the objective test it is reasonable to contend that the surgeon ought to know the seriousness of inherent consequences is directly proportional to this patient's need for that information.[95] Even a slight risk, given the obvious interest and interests of the patient, is subject to a warning under the objective and apparent-subjective tests. In many cases involving inadequate warning, the plaintiff failed to ask specific questions. Where she does ask such questions, she is entitled to a full answer, as was held in three jurisdictions in *Rogers v Whitaker, Reibl v Hughes* and *Sidaway.*[96]

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[91] Cf. Ch. 5 on the expert in context.
[92] This is of greater significance in British jurisdictions and will receive fuller treatment in Chapter 6.
[93] She had partial blindness in the other eye prior to surgery.
[94] Because the lay person cannot appreciate the vagaries of sympathetic ophthalmia.
[95] With the notable exception of a patient in a state of denial.

3.2.2.3. SOUTH AFRICA

Until the appeal judgement in *Castell v DeGreef*, South Africa had followed a position like that expressed in English and Scottish Courts. In *Blyth v van den Heever*, Corbett JA set out a *Bolam* style test when confronted with the question as to what constitutes negligence in a therapeutic medical context.[97] On disclosure of information, the court in *Lymbery v Jefferies*[98] held that it is not necessary to inform a patient of all complications which could arise and that 'there should be some evidence for the inference that had the explanations as to the danger been given, she would have refrained from the treatment.'

The benchmark case in medical negligence is *Van Wyk v Lewis*[99] in which it was accepted that the degree of skill to be expected is that customarily adopted by the relevant branch of the profession concerned; not the highest possible degree. These are decisions which were to have been expected in 1924 and 1925 when South African and English law were very much closer than they are today[100] and when the issue of disclosure was not high on the agenda.

These cases continued to gain approval in South African courts with regard to standards of treatment. However, some movement was evident regarding disclosure of inherent risks, which showed that two duties may be separated. In *Richter v Estate Hammann*,[101] Watermeyer J conceded that failure to disclose risks may amount to negligence.[102] Considering the doctor's dilemma in a decision reminiscent of that handed down in *Sidaway*, the learned Judge said,

> 'It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem.'[103]

This indicates simply that there are two separate duties (of information and in treatment) and that the standard is the same for both.

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[96] In England, however, Kerr LJ held in *Blyth v Bloomsbury Health Authority* [1993] 4 Med LR 151 that a patient is not necessarily entitled to a full answer because the consultation is subject to professional privilege (which argues that it is the practitioner who best knows what is in the best interests of the patient).
[97] *Blyth v van den Heever* 1980 (1) SA 192, 220-21 (negligence *simpliciter*).
[98] *Lymbery v Jefferies* 1925 AD 236, 238 & 240.
[99] *Van Wyk v Lewis* 1924 AD 438.
[100] Indeed in *Van Wyk v Lewis,* Wessels, JA cited *Halsbury's Laws of England* - although at that stage *Van Wyk v Lewis* drew heavily on American decisions.
[101] 1976 (3) SA 226 (C).
[102] *Richter v Estate Hammann*, 232G.

In making up its own mind and 'maintaining judicial sovereignty over expert evidence',[104] the court in *Richter* asserted itself and potentially eroded the *Bolam*-style test. Here, the Cape Provincial Division was leading towards the situation which was to be broached in *Reibl v Hughes* and which had already been outlined in *Canterbury v Spence.* In *Richter*, as in *Sidaway*, one is able to detect an erosion of the *Bolam* principle as useful to the practitioner only in respect of disclosure standards:[105] judicial sovereignty over expert and lay evidence. *Richter* had opened the door to the prudent-patient standard. Courts asserted dominance over the medical profession and adopted *Sidaway* together with its qualifications of *Bolam.*

The nature and extent of the duty to warn a patient of risks inherent in a surgical procedure was affirmed at first instance in *Castell v De Greef*[106] as embracing the normal and expected consequences. There the Cape Provincial Division discussed the doctrine of informed consent more fully. Significantly, Scott J affirmed both *Sidaway* and *Bolam,* noting that the House of Lords in *Sidaway* had declined to adopt *Reibl v Hughes* or *Canterbury v Spence* and instead had reaffirmed *Bolam.*

On appeal, *Castell v De Greef*[107] was overturned in part and the 'Gospel according to *Rogers v Whitaker*' was adopted. Ackerman J considered a wide range of authorities including *Sidaway*, *Rogers v Whitaker* and *Reibl v Hughes.* He found the Australian case *F v R*[108] important, yet based his judgement on the South African law of delict to hold that the defence of *volenti non fit iniuria* was available. The plaintiff averred that the surgeon was under a duty to warn of material risks and complications which might flow from cosmetic breast surgery, as well as alternatives to the proposed procedure. Ackerman J held that it was not in dispute that consent had to be obtained from the patient prior to surgery, quoting Neser J in *Rompel v Botha*:

> 'I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent - it is consent without knowledge of the possible injuries.'[109]

It is this argument that returned the informed consent case scenario to the context of *culpa* rather

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[103] This was approved by *Castell v De Greef* 1993(2) SA 501, 517F-H.
[104] Goldrein 1378 (October 7 1994).
[105] In the same way, although less dramatically, in which it has been eroded in Australia in *Rogers v Whitaker* and more so in *Reibl v Hughes* in Canada.
[106] *Castell v De Greef* 1993 (3) SA 501, 507 (first instance decision).
[107] 1994 (4) SA 408.
[108] *F v R* (1983) 33 SASR 189.
[109] *Rompel v Botha* 1953 Transvaal Provincial Division, unreported - quoted in *Castell v DeGreef* at 417H.

than negligence. Ackerman J went on to consider the matter in terms of the patient's rights, siding with Lord Scarman in *Sidaway*. He disagreed with the 'reasonable doctor' test as articulated in *Richter v Estate Hammann* saying that it did not leave determination of the issue in the hands of the medical profession because the court remains the final arbiter on the issue.[110]

The plaintiff had averred that she did not give full consent. The defence was a rebuttal in the form of the *volenti* defence which would justify an otherwise wrongful delictual act. Having considered authority from other jurisdictions, Ackerman J said,

> 'As already indicated, the matter is approached somewhat differently in South African law, the inquiry being whether the defence of *volenti non fit iniuria* has been established and in particular whether the patient's consent has been properly informed consent.'[111]

Significant to the present thesis, he went on to note that 'on either approach the same, or virtually identical, matters of legal policy are involved'.[112]

Outlining the *volenti* defence, the judgement in *Castell v DeGreef* held the following to be required for success:[113] the consenting party must have knowledge, awareness, appreciation and understanding of the nature and extent of the harm or risk and have consented to that harm or to have assumed that risk. Further, that consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.' This is a question of fact and is no different from the *post facto* inquiry in any jurisdiction in which the court asks, on the facts, what information the plaintiff had actually been given and had understood.

Following a consideration of materiality in the instant case, Ackerman J concluded that this patient had not given her informed consent to the surgical procedure in question and consequently that the defence of *volenti non fit iniuria* failed. This case indicates that the test in South African law as regards whether a patient gave informed consent is, under the *volenti* defence, a subjective and factual one. This is a very recent move away from the English and Scottish positions as well as from negligence principles. It is broadly in line with the Australian position yet different from the Canadian test, which contains a greater degree of objectivity.

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[110] 419C.
[111] 423B-C.
[112] He cited a passage from the judgement of King CJ in *F v R* on the conflict between the doctor's duty and the patient's rights.

3.2.3. THE LAW IN SUMMARY AND CONTRAST

The law in both Scotland and England has rejected the doctrine of informed consent as describing the standard of care.[114] But when the patient entrusts himself to the doctor he expects, and is entitled, to be kept fully informed about decisions which have to be taken and which may concern his welfare, even if the doctor is considered to know best. The difference between British and Commonwealth jurisdictions on this point is between the reasonable doctor and the prudent patient - between a medical and patient centric standard. This exposes judicial policies of different jurisdictions as protective of different interests.

Current trends indicate that the *Bolam* and *Hunter v Hanley* standards are passé[115] in Canada, America and South Africa where courts now favour tests which take the patient's rights into account to a greater extent. However, Lord Caplan in *Moyes* correctly acknowledged that the standard in *Hunter v Hanley* is flexible as standards change within the medical profession. What this means is that the standard is the same in a different context rather than that the standard is flexible, as any legal standard or test should be.

This acknowledgement came in the context of the delict principle that conduct should be assessed at the time of injury: Lord Caplan said that the medical practices at litigation in 1990 may differ from those at the time of injury in 1981.[116] This standard is not *prima facie* as flexible as the *Bolam* standard because *Hunter v Hanley* requires unanimity of method while *Bolam* requires acceptance by or accord with a responsible body of opinion. The central linguistic difference between the two tests may be expressed as follows: the *Bolam* test is a negative one which tells the court when a practitioner *is not* negligent, while the test in *Hunter* is a positive one, which tells the court when the practitioner *is* negligent. It has already been argued that the difference between the two tests remains a linguistic one.

In *Sidaway* four of the five Law Lords preferred a more patient-oriented standard

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[113] 425H-J.

[114] Indeed, it 'has come down firmly against the view that the doctor's duty to the patient involves at all costs obtaining the informed consent of the patient to specific medical treatments.' Lord Caplan in *Moyes v Lothian Health Board* 1990 SLT 444, 449, [1990] 1 Med LR 463, 467. See also the judgement of Lord Bridge in *Sidaway.*

[115] Consider, for example, arguments advanced by Goldrien in Goldrein, Iain S. 'Bolam - Problems Arising Out of "Ancestor" Worship' (1994) 144 *New Law Journal* 1237.

[116] *Moyes* at 450I.

including disclosure of information regarding material or substantial risks; information with which the disadvantages and dangers are communicated, as well as full and truthful responses to questioning by patients.[117] Lord Templeman spoke of the need for information standards suitable to a balanced judgement, saying that he '[did] not subscribe to the theory that the patient is entitled to know everything or to the theory that the doctor is entitled to decide everything', thereby positioning himself somewhere between autonomy and paternalism.

In this way, the House of Lords in *Sidaway* adopted the principles embodied by the American doctrine into the English law of negligence in a diluted form. The court accepted the need for information, retained the power to determine adequacy and materiality of the information given and reduced the authority of the doctor's decision - presumably in favour of the patient. If negligence is based on a professional standard, that standard might be prone to lowering in order to protect the profession from within: the 'conspiracy of silence' described by several authors and judicial opinions.[118] For this among other reasons, proponents of the objective test[119] advocate a 'prudent patient' test, while the medically-based standard is becoming less and less able to hold water. However, as we shall see in Chapters 5 and 6, the *Bolam* standard is now able to support the plaintiff's case.

In *Daniels v Burfield* and *Rogers v Whitaker,* the Australian Supreme Court followed *F v R* and categorised it as an 'informed consent' case in which, three years before *Sidaway*, King CJ had rejected the conclusiveness of evidence of accepted practice. Judges remain under no obligation to scrutinise medical practices because that is outwith their realm of expertise. But they can consider the amount of information required by patients under the category of reasonableness and indeed the *Wednesbury* unreasonableness of having omitted material advice and information.[120] In *Rogers v Whitaker*, Mason CJ *recognised* 'informed consent' as an ideal to which practice can and should aim, though he saw it as 'amorphous' when considered as a duty.[121]

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[117] Gillon, R 'Consent' (1985) 291 *British Medical Journal* 1700, 1701.
[118] *F v R* (1983) 33 SASR 189, 194 per King CJ, for example.
[119] Such as Ian Kennedy 'The Patient on the Clapham Omnibus' (1984) 47 *MLR* 454.
[120] In the sense expressed by *Associated Provincial Picture Houses Ltd v Wednesbury Corp.* [1948] 1 KB 223.
[121] *Rogers v Whitaker* [1994] 4 Med LR 79, 83.

With *Rogers v Whitaker* and *Chappel v Hart*[122] the Australian position has moved closer to that in Canada with regard to the objective test, and in England *Sidaway* did not conclude the debate.[123] When it comes to informing patients of inherent risks, the use of the professional standard by the courts falls short of the ethical principle of autonomy and because the judgements in *Sidaway* and subsequent cases in England now demand it through their qualifications of *Bolam*.[124]

Having argued that different tests are used to determine the standard of care, it is apparent that these tests interrogate, from different points of view, the materiality of information omitted. It is now possible to consider what constitutes material information. Informed consent, as a doctrine, comprises a two-stage test. The first stage is the test for the standard of care – discussed in the present chapter. The second is the test for legal causation – discussed in the next chapter. Both stages provide fertile ground for judicial policy formulation and application and both stages depend on a definition of materiality. It is this that renders materiality pivotal to any disclosure case.

3.3. MATERIALITY

This term forms an important and controversial part of the law of insurance. In insurance law, policies may be voided for non-disclosure of a material fact.[125] The analogy here is that the law of informed consent to medical treatment also reaches a critical point in any judgement at which the plaintiff's knowledge of a material risk, and that patient's willingness to undertake (or underwrite) that risk, proves pivotal. The court will have to formulate a test to determine in each instance whether a particular piece of information was material.

The insurance case law indicates that a fact is material if it would influence the decision of the prudent insurer whether to insure the risk. Similarly, in the law of informed consent, the

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[122] *Chappel v Hart* 1998 HCA 55
[123] Cf. 6.2.
[124] Cf. 3.3.4. & Cf. 6.3.
[125] The Marine Insurance Act 1906 requires disclosure of material facts. S18(2) reads, 'every circumstance is material which would influence the judgement of a prudent insurer in fixing the premium, or determining whether he will take the risk.' This section has been interpreted by the case law in *Pan Atlantic Insurance Co v Pine Top Insurance Co* [1992] 1 Lloyd's Rep. 101, [1994] CLY 2698 and *Deutsche Ruckversicherung AG v Walbrook Insurance Co Ltd* [1996] 1 All ER 791. As will become apparent, not only is there no statutory test for materiality in respect of informed consent cases, but jurisdictions apply different judicial tests.

court will formulate a test which will ask whether or not information on a particular risk would have influenced the decision whether or not to undergo the medical procedure in question. In this way the test for materiality of risk will work in conjunction with the test for legal causation and that for the standard of care. This is because the duty is to warn of a material risk and a material risk is one which would influence the patient's decision in the treatment offered.

The doctrine of informed consent comprises tests for causation and for the standard of care and materiality. These two tests dovetail with one another.[126] What will be argued in Chapter 4 on Causation will draw on what will be argued here on materiality - the emphasis here being on those jurisdictions which accept the doctrine as describing the scope of the duty of care - only once the duty of care facet has been won by the plaintiff is a judicial discussion of causation of any consequence.[127]

It is at the point of *materiality* that the doctrine has been expanded in many American jurisdictions and adopted to varying degrees in parts of the Commonwealth in the form of a more subjective test for causation.[128] Dealing as we are with a wholesale American doctrine, it is important to consider this facet because it is central to the doctrine itself. The cases with which we are dealing here are those which fall within what has been described as the *informed consent fact genre*.

To recap: what these cases have in common is a pursuer or plaintiff who was allegedly not informed of a risk inherent in the medical procedure performed. That risk must have eventuated for litigation to occur; it would be alleged that lack of knowledge of that risk was the legal cause of the injury suffered.[129] The plaintiff would have to prove that a duty existed which included the provision of information concerning the risk which eventuated. To determine whether this is the case, courts need to assess whether that risk was material in the circumstances.

This is defined from different viewpoints in different jurisdictions: from the point of view of the medical community in British jurisdictions, from that of the prudent patient in

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[126] The tests for causation will be dealt with in the next chapter.
[127] Or if negligence is established through the use of *Bolam* and *Hunter v Hanley* in British jurisdictions
[128] Cf. 6.2.1. on the American expansion of the doctrine of informed consent using definitions of materiality.
[129] Cf. Chapter 4.

Australia, from that of the prudent patient objectively assessed in Canada and somewhat *post facto* in South Africa through *volenti* spectacles.

It is instructive to consider how American jurisdictions define the term before considering what leading cases have to say on this matter in other jurisdictions. This will follow the same 'geo-chronological' route taken by the doctrine itself.[130] In *Canterbury v Spence* a material risk was defined as one to which 'a reasonable person in what the physician knows or should know to be the patient's position, would be likely to attach significance ... in deciding whether or not to forego the proposed treatment.'[131]

3.3.1. CANADA

According to the Law Reform Commission of Canada in 1980,[132] all material or relevant facts which could influence the patient's decision whether to undergo treatment should be disclosed. The test for materiality is to be objective but is to become subjective to the extent that the doctor knows the patient and as a consequence expectations of that doctor are raised.

In *Reibl v Hughes*, the Supreme Court of Canada held that the proximate relationship between patient and surgeon gives rise to a duty of disclosure of all material risks. The court then cited *Hopp v Lepp*[133] as it defined a material risk as one to which a reasonable person in the plaintiff's position would attach significance,[134] that is in making it more apparent-subjective or modifying the degree of objectivity. This is the same test as that for causation:[135] that is from the point of view of the particular patient as objectively assessed on the basis of reasonableness. Chief Justice Laskin went further when he argued that to allow expert medical evidence to determine materiality is tantamount to handing over to the medical profession the determination of both the standard of care and the matter of its breach. He found that expert medical evidence is important and is relevant to findings of fact that have to do with the extent of risks and the alternatives to the recommended procedure.

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[130] That is from America to Canada, Australia and South Africa, in that sequence.
[131] *Canterbury v Spence* 772.
[132] *Consent to Medical Care.* Law Reform Commission of Canada, 1980. Kirby 71.
[133] Ibid.
[134] It was held that, 'Materiality connotes an objective test, according to what would reasonably be regarded as influencing a patient's consent.' (1981) 112 DLR (3d) 67, 81. This was an overt adoption of the dictum in *Canterbury v Spence.*

As far as materiality was concerned, Laskin CJC found that medical evidence would have a bearing on the issue, but the issue would be determined by that evidence in conjunction with other factors. This means that this is an area in which expert evidence is important, though not decisive. It contrasts with the position in Britain and differs subtly from that in Australia, but ultimately it will be a matter for judicial determination in all jurisdictions.

That this position is stable in Canada has been reiterated in *Lenis v deVilliers*[136] in which it was held that the test is relative to the reasonable patient rather than to the reasonable practitioner. When the court determines what constitutes a 'material risk', the test is what the reasonable patient in the actual patient's position would have considered material. This test is to be tempered with a degree of objectivity through the court's exclusion of hindsight.

Most recently, in *Arndt v Smith* the Court held, 'The entitlement of the patient to know the full facts about risks and to make a personal assessment of those facts in the light of the patient's own view of his or her own circumstances is a major determinant of whether there has been the disclosure required by law.'[137] Another major determinant is the fiduciary relationship between patient and practitioner - that is the actual context of the consultation. The establishment by the court of this position precedes the court's determination of causation and indeed predetermines the test to be adopted in the latter inquiry.

3.3.2. AUSTRALIA

A similar, though more subjective, position was adopted in Australia in *Rogers v Whitaker*. In that case Mason CJ said,

> 'The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment: a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it *or* if the medical practitioner is or should reasonably be aware that the particular patient, if warned, would be likely to attach significance to it.'[138]

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[135] *Reibl v Hughes* (1981) DLR (3d) 1, 5-6 & 15-17.
[136] 1992 Ont. C.J. LEXIS, p10.
[137] [1995] 7 Med LR 108, 114.
[138] 83. Own emphasis. Cf. Ch. 4 on Causation.

In *Rogers v Whitaker* the test for materiality was being used in conjunction with the causation inquiry and is clearly subjective whether considered from the point of view of the patient (by asking what information a patient in the position of the actual plaintiff would have required) *or* from the point of view of the medical practitioner (by asking what can reasonably be expected of that practitioner *vis-à-vis* the reasonable patient in the actual plaintiff's position). Therein lies the difference between the Canadian and Australian tests. Considering the matter in the alternative allows Australian courts to use a subjective test first, as dictated by the law of torts, and then to turn it into an objective expectation of the practitioner. It also poses problems for the practitioner who will be looking to judicial tests as a form of guidance on how to avoid legal liability; that practitioner will be offered a test which is ambiguous.[139]

This position was confirmed in *Hart v Chappel*[140] in which it was held that the test for establishing which inherent risks are material is whether the 'medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.' Again, this precedes and sets the scene for the inquiry into causation. However, it must be appreciated that even if a risk is held to be material on that test, a plaintiff may, on the basis of medical evidence to the contrary, yet fail to prove causation.[141]

3.3.3. SOUTH AFRICA

The position in South Africa is broadly similar to that in Canada and Australia, yet with an important difference. The court approached the inquiry from a different direction by asking whether, on the facts, the patient had knowledge of the risk which eventuated.[142] It was held that there is an obligation on the surgeon to warn of material risks, defined as those to which a person in the plaintiff's position would be likely to attach significance *or* those to which a medical practitioner might reasonably be expected to be aware that the patient would find significant, so siding with the Australian position.[143]

The difference between the two jurisdictions lies in its adaptation to the 'needs of South

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[139] Cf. Chapter 7.
[140] [1994] 5 Med LR 365, 375. For the appeal, which upheld *Hart v Chappel*, see *Chappel v Hart* 1998 HCA 55.
[141] Where, for example, a patient would have been compelled to accept the inherent material risks as a matter of medical urgency or necessity
[142] Cf. 3.4. & 3.5.

African Jurisprudence.' Under the *volenti* defence it became a test predicated on the hindsight of the court, determined as a matter of fact and then extended in a non-normative way to form an 'unimpeachable consent' to the consequences of the medical procedure. This is anomalous when considered alongside a necessarily normative test for materiality, even though it is seen by the South African court as analogous to the Australian position from a policy point of view.[144]

3.3.4. ENGLAND

British courts and academic opinion are at odds with one another on this issue insofar as academic opinion sides with the prudent patient standard more than it does with the reasonable doctor standard. Prior to *Sidaway*, the South Australian Supreme Court had in *F v R*[145] agreed with the rationale in *Reibl v Hughes.* This is important because Australia had until that time followed a position broadly similar to that of England in accepting the *Bolam* test.

In *Sidaway*, Lord Scarman agreed with the rationale on materiality iterated in *Canterbury v Spence*, but his was a minority judgement.[146] In that case counsel for the plaintiff invited the court to adopt the doctrine of informed consent, of which materiality forms an integral part. Because the majority of the House declined that invitation and held that under the *Bolam* test the surgeon was under no such duty, it was not necessary to formulate or apply any definition of materiality. This is because, as Lord Diplock put it, a doctor's duty towards his patient comprises,

> 'a single comprehensive duty covering all the ways in which a doctor is called on to exercise his skill and judgement in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or as a specialist have been engaged. This general duty is not subject to dissection into a number of component parts ...'.[147]

However, because he accepted the doctrine of informed consent of which it is an integral part, Lord Scarman did consider materiality, saying,

> 'The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if on a reasonable assessment of his patient's condition he takes the view that a warning would be

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[143] *Castell v DeGreef* 1994 (4) SA 408, 426G.
[144] Cf. 3.4.2. & 3.4.3. Indeed, the test in *Castell v DeGreef* was taken *verbatim* from *Rogers v Whitaker.*
[145] 33 SASR 189, 192-193.
[146] [1985] 1 AC 871, 887.
[147] Ibid., 893. Cf. 3.2. on different tests for different types of negligence.

detrimental to his patient's health.'[148]

In time this part of Lord Scarman's dissenting judgement may itself prove material to the resolution of informed consent cases in England.[149]

The majority judgement in *Sidaway* has remained largely unchanged in England. That said, it must be borne in mind that there has been some modification of the *Bolam* standard as regards disclosure of inherent risks. Where the *Bolam* standard proves useful to the plaintiff's case in one facet of the duty of care and not in others, does this not indicate a tacit separation of the various aspects of the duty of care?[150] For example, under the causation head in *McAllister v Lewisham*,[151] Rougier J adopted a subjective test, which took the plaintiff's personality into account. Similarly, *Smith v Tunbridge Wells*[152] and *Newell and Newell v Goldenberg*[153] indicate a more patient-oriented *Bolam* standard within the causation inquiry.[154]

In considering what a plaintiff might or might not have done in the presence of information which was absent prior to treatment, is the court not considering the materiality of that information? And in taking the plaintiff's personal circumstances into account, is the court not considering the materiality of that information from the plaintiff's perspective? These are rhetorical questions which cast the *Bolam* test as exclusively useful to the medical practitioner in a dubious light. Yet the test still reigns and hence whether or not a risk would have been material to the patient (and have had a probable effect on causation in a subjective test) remains irrelevant until a more subjective test is found for the standard of care.

3.3.5. SCOTLAND

The court in *Moyes v Lothian Health Board*[155] and *Gordon v Wilson*[156] upheld the test in *Hunter v Hanley*. The first of these cases confirmed that any warning is to be governed by medical

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[148] Ibid., 889. Here Lord Scarman was stating the law as it was; elsewhere in his judgement he stated what he thought the law should be as he approved of *Canterbury v Spence* and *Reibl v Hughes*.
[149] Cf. 6.2.2.
[150] Chapters 4 & 5 will be devoted to a fuller discussion of this topic.
[151] [1994] 5 Med LR 343, 353.
[152] [1994] 5 Med LR 334.
[153] [1995] 6 Med LR 371. See also *Lybert v Warrington Health Authority* [1996] 7 Med LR 71.
[154] Cf. 6.2.
[155] 1990 SLT 444, [1990] 1 Med LR 463.
[156] 1992 SLT 849.

criteria unless it is established as necessary.[157] This had the effect of defining materiality from the point of view of the medical profession as a whole. The court in *Gordon v Wilson* went further in holding that where two responsible bodies of medical opinion existed, negligence could not be found.[158] This meant that were the court to have been confronted with the materiality question where two opposing bodies of evidence were to have been led, no negligence would be found. This would be the case irrespective of whether the doctrine of informed consent were accepted by all practitioners because the inquiry into materiality comes after the decision as to whether the duty of care includes the provision on information on material risks.

However, in *Goorkani v Tayside Health Board*[159]the Court of Session found that the medical practitioner who failed to warn that a certain immunosuppressive drug designed to save the patient's sight could cause sterility, was negligent in making that omission. After that the court had to consider causation and to formulate a test for that stage of the legal inquiry. Hence it is possible to establish negligence on the standard in *Hunter v Hanley*; it is in the causation inquiry that the pursuer's case meets a more onerous hurdle.

3.3.6. COMMUNICATION

From the preceding paragraphs, it is apparent that there are several different tests for materiality. It is an issue which the court will not need to confront until it is agreed that the duty of care includes the provision of information on material risks and alternatives. Only at that point is it necessary to define which risks are material in the circumstances and from whose perspective. This inquiry dovetails with that into causation because a risk is often material to the decision whether or not to consent to treatment at all.

By this stage *communication* will have emerged as one of the main thrusts of the informed consent scenario. This involves a factual inquiry: was the information, which the court held to be material, actually communicated to and understood by the plaintiff-patient? In South Africa this involves almost the whole of the inquiry, but in other jurisdictions it raises, to a greater degree, questions of evidence, practitioner's notes, the expert witness and memory of the

[157] *Moyes v Lothian Health Board* 1990 SLT 444, 449G-K, 45B-L and F-L.
[158] *Gordon v Wilson* 1992 SLT 849, 852F & 852L-853C.

consultation between practitioner and patient.

Communication has been defined *inter alia* by Ladeur[160] as a synthesis of information, communications and understanding. In the context of English and Scots law, in a comment reminiscent of the *Grannum* test,[161] Balen argued that a doctor needs to question the capacity of the patient to comprehend information.[162] What is needed in this context is a set of judicial criteria which has the approval of the medical community - of that responsible body of medical opinion so dear to the judiciary. There are indications that this is possible in England.

England and Scotland maintain a medical professional test and so cannot adopt the doctrine of informed consent because the doctrine considers materiality from the patient's point of view, even though the judgement may be expressed in terms of the standard of care of the reasonable doctor. The need to confront or to alter the test for causation arises only when the court accepts the doctrine or decides that the pursuer has proved the *duty of care* facet of their case in terms of *Bolam* or *Hunter v Hanley.*[163]

It is impossible to convey to the patient all the medical knowledge of the trained medical practitioner; consent will be imperfect to the extent that it is ill-informed. Indeed, at first instance the court in *Castell v De Greef* applied *Lymbery v Jefferies*,[164] in which the Appellate Division had held that it is not necessary to inform a patient of all complications which could arise from a given procedure. And as Mr Justice Kirby put it, 'the very notion of informed consent implies a sophistication on the part of the patient'.[165] If a patient is genuinely unable to comprehend, then autonomy is nebulous and the patient will fall under the applicable Mental Health Act or Children Act.

The doctrine of informed consent suggests that a doctor's role is simply to inform. But

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[159] [1991] 3 Med LR 33.
[160] Ladeur, K. 'Perspectives on a Post-modern Theory of Law: a Critique of Niklas Luhmann, "The Unity of the Legal System"' in Teubner G *Autopoietic Law: a New Approach to Law and Society*. 1988. Walter de Gruyter. New York. 254; see also King, M. 'The Truth about Autopoiesis' (1993) Journal of Law and Society. 218, 219 (communication comprises information, utterance and understanding) and Teubner, G. *Autopoietic Law: a New Approach to Law and Society*. 1988. Walter de Gruyter. New York.
[161] Cf. 1.1.4.
[162] Cf. 3.2.1.
[163] Cf. Chapter 5.
[164] 240.
[165] M D Kirby 'Informed Consent: What Does it Mean?' (1983) 9 *Journal of Medical Ethics* 69, 73. Cf. 6.1.

the patient's understanding should be the emphasis. In communication terms this would mean that ideally the practitioner would take steps to become aware of how much information the patient requires for that patient's decision to have been adequately informed[166] and to insure that the patient's communication of that decision is as unfettered as possible.[167]

The standard in *Reibl v Hughes* is that a normal intelligent patient would want an objectively reasonable explanation of the risks involved according to a patient-based standard. This middle ground between the American vitiation of consent giving rise to an action in negligence or battery, and the medically based gospel according to *Bolam* and *Sidaway*, is to be preferred as the 'right approach'.[168]

3.4. POLICY

It is now appropriate to simply draw attention to aspects of judicial policy at this stage of the informed consent inquiry. To raise such a topic begs the question *what is policy?* Dictionary definitions lean towards conduct which is characterised by prudence and sagacity achieved through reason and deliberation. This is the case in informed consent as judiciaries consider the likely effect on the common law of the ethical or moral decision they are to reach.[169]

Policy *per se* denotes a certain pragmatism which has moral undertones. In the context of the law of torts or delict, such a mechanism may act as a limitation device. A prime example of this is that of nervous shock cases which use proximity as a device for limiting the number of potential plaintiffs that may claim; it is the policy of the court to keep the number of claimants low. Similarly, in medical negligence cases, there must be an established relationship between the parties for a duty of care to arise. After that the judiciary may assert a moral reason to limit or to extend liability. This is often expressed as 'the right of the patient to know'[170] or, conversely, the need to stem the flow of litigation by favouring the medical practitioner.[171]

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[166] See van Oosten, FFW 'Disclosure Documents and Informed Consent: the Pros and Cons.' (1993) 12 *Medicine and Law* 651-656 in which he appreciates the role which individuality has to play.
[167] The example of cases of aphasic patients outlined in 2.3. shows that there can be some grey area as regards mental competence and the ability to express one's preferences to the doctor's satisfaction.
[168] *Videto v Kennedy* (1981)125 DLR (3d) 127, 133-4, cited in Dickens at 256-57.
[169] Such as the opening of floodgates of litigation by adopting a policy favourable to patients.
[170] As in America, Canada and Australia, and indeed in the minority judgement of Lord Scarman in *Sidaway*. Cf. 6.3.
[171] As it is in England and Scotland.

Whichever particular policy is asserted, policy *per se* concerns the judiciary's self-proclaimed right to decide on these matters.

On the doctrine of informed consent, Robertson observed that it 'was born at a time when judicial policy in the United States was beginning to turn in favour of the plaintiff in medical malpractice cases.'[172] The matter of the standard of the duty of care *is* a policy issue. A duty of care is imposed when it is considered fair and reasonable to do so, based on dicta such as that of Lord Atkin in *Donoghue v Stevenson.*[173] The medical practitioner having the patient 'in contemplation' falls within the ambit of this dictum.

The determination of the standard of that contemplative duty will be made on the basis of legal policy and will appear as a finding of fact. The imposition of a particular standard of care is a major policy area because essentially the court is asked to pronounce on whether the duty of care includes the provision of information material to the patient's decision whether or not to undergo the treatment proposed. We are dealing here with the policy of compensating victims of non-intentional torts where liability is based on an omission and where there is an anterior duty of care.

The real function of *culpa* and the judicial definition of the scope of the duty of care is to allow courts discretion to increase - or indeed decrease - limitations on liability within the law of torts or delict. This makes the scope of the duty of care an important policy device.[174] Moral factors such as *proximity* come into play where a positive duty to act is held to exist by virtue of the relationship between the parties[175] such that proximity itself is defined in terms of reliance; incrementalism is a technique whereby the boundaries of proximity are extended. In such instances, courts use categories such as 'reasonableness' to test reliance and so to justify the availability of remedies.

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[172] Robertson, G. 'Informed Consent to Medical treatment' (1981) *Law Quarterly Review* 102, 110.
[173] [1932] AC 562, 580: 'The rule that you are to love your neighbour becomes in law: You must not injure your neighbour, and the lawyer's question: Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts of omissions which you can reasonably foresee would be likely to injure you neighbour. Who then in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts and omissions which are called into question.
[174] Consider *The Council of the Shire of Sutherland v Heyman and Another* [1985] 59 ALR 564 on the standard of care as a policy divide for limitations on liability.
[175] Consider Chapter 1 on the duty of care and the proximate (or fiduciary) relationship between the litigating parties.

Because moral attitudes towards liability for omissions are often sceptical, courts are hesitant to impose liability. Such hesitancy is more marked in British jurisdictions where liability for failure to inform a patient of inherent risks is circumscribed by *Bolam* or by *Hunter v Hanley*. However, once courts accept such liability in principle, the writing is on the wall. Because these are moral issues, courts often slip into rights discourse to justify the granting of remedies on the basis of omission-liability, as did Lord Scarman in *Sidaway*. Policy operates in determining to whom a duty is owed, so making the duty facet of the inquiry another policy zone. The question before the courts in Britain, for example, would be 'what possibilities are open to the plaintiff and to the practitioner through the use of the tests in *Bolam* or *Hunter v Hanley*?'[176] The question before courts in Canada and Australia, on the other hand, would be 'if there is a duty to warn of material risks which positions the definition of materiality as the standard, what flexibility is possible under that standard?'[177]

3.4.1. RATIONALE

The purpose of the law of torts or delict is to compensate a victim for damage wrongfully caused. What presents first is the injury itself, without which no action can exist. To understand against whom any such action might lie, the injured plaintiff asks whose act or omission factually caused the injury. If that person owed a duty of care in the circumstances of the injury, damages may follow (on proof of legal causation). This is because in this area of law plaintiffs bring the action having answered the questions in that order. However, judgements of the courts approach the issue from the opposite direction, asking first whether the actual defendant owed a duty of care in the circumstances of the case and then whether that defendant was in breach of that duty in such a way as to have caused harm to the plaintiff.

Courts also have to find a legal category for the matter before them. In the informed consent scenario, courts across the Commonwealth argue the matter in the tort of negligence.[178] The question before the court is whether in the situation being adjudicated the medical practitioner owed the patient a duty of care which included informing the patient of the particular inherent risk which did in fact eventuate and cause harm. Omission in this instance

[176] Cf. the discussion of the 'erosion' cases in 6.3.
[177] Chapter 6 will consider where the doctrine may conceivably be taken in the future.

forms the basis for liability. The decision whether or not to hold that a duty exists is a policy matter, as is the test which will determine whether or not the duty was breached and indeed whether or not the breach caused the injury actually suffered.

Finding a legal category involves asking 'what is the fault?' If the injury can be said *sine qua non* to have been caused by lack of information on an inherent risk to the procedure in question, and the court considers that information to have been material to the patient's consent, then the fault element lies with the information which was allegedly absent. The question which follows is 'was there a duty in these circumstances to divulge that piece of information?' This is inseparable from the question, 'was this piece of information *material*?'

If, in Britain, the doctor's duty of care were to include the disclosure of all risks material to the patient, then the law of medical negligence based on consent would become as patient-centric as that of Australia unless a more objective test for causation were adopted. This is one reason why England is holding on to the *Bolam* test as articulated in *Sidaway*: if they let that backstop fall, then with an already well-established subjective test for causation, radical and swift change would be unavoidable.[179]

The *Bolam* test may be eroded by the assertiveness of the court over evidence. Yet the *Bolam* standard in England is also eroded through the *Bolam* test itself by arguing that a doctor's allegedly negligent behaviour is based on a responsible body of medical opinion.[180] *Bolam* is more a rule of evidence than a rule of law and as current opinion evolves so standards are able to come in line with new developments in medicine. Paradoxically, this has been argued as the strength of the test, yet it means in effect that *Bolam* can be used to adopt a form of the doctrine of informed consent.

With the current trend towards more comprehensive disclosure in practice,[181] the question arises: is good practice defined by the law, or is the *Bolam* standard defined by currently accepted interpretations of what constitutes good practice? This difference would be

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[178] As discussed in Chapter 1 and, latterly, with the exception of South Africa.
[179] Cf. Chapter 4 for a detailed discussion of causation.
[180] Cf. Chapter 6.

illusory in Britain were a responsible body of medical opinion to agree on court guidelines which amount to the adoption of some form of consent doctrine. That way they would be able to maintain the *Bolam* or *Hunter* tests yet still establish more balanced consent principles while not fully accepting informed consent as a wholesale doctrine.[182]

3.4.2. THE SOUTH AFRICAN EXAMPLE

Such a judicial adaptation of the doctrine occurred in South Africa in *Castell v De Greef*. In that case the plaintiff averred that the surgeon was under a duty to warn of material risks, complications and alternatives so arguing for a displacement of the 'reasonable doctor' test. The judgement in *Castell v DeGreef* was based on the South African law of delict. Having considered a test for materiality the court held that this patient had not given full consent and consequently that the *volenti* defence failed. The South African court found in *volenti* a legal category for consent and risk-taking. On policy grounds, the court then transposed that scenario to another context in order to test whether consent had been given. This involved a *post facto* inquiry and allowed the court to escape the category of negligence. The problem here is that success under *volenti* will mean that it will be held that the defendant was not in breach of the duty of care. This shows the importance of the sequence of the judgement: in South Africa the judgement considered policy prior to rationale, while in Britain policy emerges from the judgements themselves.[183]

Judge Ackerman pointed out that the court in *Rogers v Whitaker* had criticised the term 'informed consent' on the ground that consent is relevant to actions in trespass rather than actions in negligence.[184] He held the position formulated in *Rogers v Whitaker* to be correct, but sought to adapt it. What is important here, from ideological and precedent points of view, is the ability of a judiciary to adapt a doctrine to fit its own jurisprudential needs, and indeed to adapt the *volenti* defence to fit the medical scenario.

The use of *volenti* had two effects other than removing the issue from the realm of

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[181] S Irwin, C Fazan & R Allfrey. *Medical Negligence Litigation*. 1995. Legal Action Group. London. 22. See also *Moyes v Lothian Health Board* 1990 SLT 444, 450I in which Lord Caplan said, 'Since 1981 the view of the Medical Profession has moved further towards disclosing information.'
[182] But Cf. Chapters 5 and 6.
[183] Though occasionally the court will state that policy is the guiding rationale of the decision; Cf. 6.4.
[184] *Castell v DeGreef*, 425J-426A. Cf. 1.2.2.4.

negligence, if temporarily.[185] It placed the disclosure and materiality of risk in a contractual context and it shifted the evidentiary burden onto the defendant who must show that on balance of probabilities the plaintiff was *volens*.[186] This is done by showing that, in terms of judicial criteria, the plaintiff had in fact made a 'conscious, deliberate, informed and voluntary decision to run a known risk [which is] is therefore in its nature subjectively determined.'[187]

3.5. CONCLUSION

The whole issue of informed consent turns on 'materiality' and how, and from whose viewpoint, the judiciary defines the term. In South Africa a plaintiff would be *volens* if he knew of the inherent risks which are material. *Volenti non fit iniuria* is non-normative, yet all informed consent cases turn on whether information is or is not supplied and hence require a definition of 'materiality'. As soon as materiality is defined and that definition is judicially applied, the matter becomes intrinsically normative. But because normativity and *volenti* are mutually exclusive, this makes for distinctly incongruent law, because *volenti* is a question of fact.

The difference between jurisdictions is seen at the policy level. In Scotland and in England, policy decisions are made almost covertly in a manner in which the policy of the court emerges from the decision itself.[188] In adopting a view on informed consent in which materiality is assessed from the point of view of the medical practitioner, courts adopt a policy favourable to practitioners. The South African court, on the other hand, considered policy more overtly and in the opposite sequence by beginning with a desirable position and then considering a possible legal peg on which to hang that policy.

Canadian and Australian courts fight the corner of the injured patient by making the policy decision to assess materiality from the patient's point of view. Courts then translate that

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[185] This is temporary because in the law of delict, the verdict will be given in negligence *terms*.
[186] P Q R Boberg *The Law of Delict*. 1984. Juta. Johannesburg. 767-8.
[187] P Q R Boberg 'Some Light on the Defence of Volenti.' (1974) 91 *SALJ* 19, 27.
[188] Consider, however, the discussion on this point which will follow in Chapter 6 (6.4.) in which it will be argued that this is not always the case in the law of delict; indeed that the Court of Session has been known to begin with a policy consideration and weave the judgement around that policy, albeit in the context of a case on pure economic loss.

assessment to the language of the standard of care which is to be imposed on medical practitioners in the consent scenario, but temper that language with the language of rights.[189]

Whichever tests are employed in an assessment of the various facets of the informed consent inquiry, medical evidence is critically important. In British jurisdictions, bodies of opinion are juxtaposed and an assessment made by the court. In Canada and Australia, on the other hand, expert evidence on information actually disclosed and material to the patient is merely a useful guide to the court. In South Africa in the context of *volenti non fit iniuria*, the evidence of experts is useful to establish the facts rather than to help the court formulate a normative standard. These are positions which will be considered in Chapter 5 on the expert. However, because of what has been argued about the dovetailing of the test for materiality with that for causation, it is appropriate to precede any discussion of the role of expert evidence with a discussion of factual and legal causation.

[189] Cf. 6.3.1.

CHAPTER 4

CAUSATION

4.1. INTRODUCTION

The issue of causation deals with the alleged consequences of a negligent act or omission. In this instance the negligent omission to inform of an inherent risk in a procedure or an alternative to that procedure would be alleged to have caused the injury suffered by the plaintiff. To prove this, the plaintiff would argue that but for the omission to inform, he would not have suffered the injury because he would not have undergone that procedure at that time. This involves proving a negative and is, consequently, hypothetical.[1] This chapter will investigate this final facet of proof in disclosure cases by considering the concept of causation itself and then the tests for legal causation used in the jurisdictions under discussion.

A causal statement is one from which the inference can be drawn that two events are causally connected. We speak of a chain of causation because events are consecutive and the chain can be broken by other events. This picture is made more complex when several possible events can be said to have caused a given injury.[2] This advances the discussion from a pair of events to the relation between a consequent event and a chain of antecedent events.[3] When the cause of a harm is the sum total of the conditions of an event, this tells us that the harm is caused by the event only when that event is one element in a general set, and one without which the harm would not have occurred.

In this context it is simplistic to say that a doctor's omission to inform a patient of the possible consequences of a procedure caused the injury suffered by that patient.[4] Yet a judgement will be expressed in those terms through the use of legal tests for causation. This chapter will be examining these tests in the context of informed consent. The law asks in what conditions a single event can be spoken of as a cause; in the present context, one must ask whether a non-event – the omission to give material information to the patient – can be

[1] See Tony Honoré, 'Causation and Disclosure of Medical Risks', (1998) 114 *Law Quarterly Review* 54.
[2] This is what happened in *Wilsher v Essex*. Cf. 1.3.3.
[3] Drawing on Mill's philosophy on causation. See HLA Hart and T Honoré. *Causation and the Law*. (2 Ed.) 1985. The Clarendon Press. Oxford. 18.

considered to be causal. When an event is seen as a cause, blame or responsibility can be ascribed. This is important in the light of the desire, on the part of injured patients, for an explanation. Such a 'necessary condition' is discovered through the application of the *sine qua non* test for factual causation.

The difference between factual and legal causation is important in the informed consent scenario because of how these different facets of the causation inquiry speak to the ethical issues within disclosure cases. Through the *sine qua non test*, the inquiry into factual causation speaks to the probable, and therefore hypothetical, actions of the plaintiff. It for this reason that it is the evidence of the plaintiff which ought to carry most weight. This true is in the case of Canada and Australia, though significantly not so in Britain.[5]

If the negligent non-disclosure on the part of the medical practitioner can be said to be a *conditio sine qua non* of the plaintiff's injury, the court will go on to consider legal causation. For this final facet of the inquiry, the court will ask whether the omission was the *causa causans* of the plaintiff's injury. Legal causation is synonymous with words such as direct, decisive, proximate, real and substantial[6] and is related to the absence of a *novus actus interveniens* which may be said to have broken the chain of causation between the negligent omission and the injury. It is difficult to think what event, if any, could constitute a *novus actus* in the informed consent inquiry.

This difficulty stems from the fact that within the doctor-patient relationship, confidentiality and privacy are highly esteemed values. Other than in the context of a referral, there is unlikely to be any event, related to the plaintiff's condition and the medical indications for and against surgery, which is likely to constitute a *novus actus* between wrongful omission and injury. This follows from what was argued in Chapter 2 on the relationship between doctor and patient which is accepted judicially and being constituted by reliance and an imbalance of power in the context of which the patient tends to accept the doctor's advice with little questioning until after injury has been suffered. This, in turn, means that the informed consent inquiry turns almost entirely on the inquiry into factual causation, because legal causation is less important and because the rest of the case will turn on the court's definition of materiality which

[4] Because the surgery itself would have caused the injury.
[5] Chapter 5 will go on to consider this point in greater depth.

itself has a direct bearing on factual causation.

That is not to say that legal causation is unimportant. Two factors are said to be important in the determination of the *causa causans*: reasonable forseeability and the sequence of events. The latter has been considered above. Reasonable forseeability is about the patient's value system which courts would expect the reasonable medical practitioner to be aware of if a particular injury is held to be reasonably forseeable. If the *sine qua non* test is both a subjective one (which asks what the patient would have done) and a hypothetical one, this means that there is not much room for paternalism. This, the cynic might argue, is why British jurisdictions adhere to a more paternalistic test for the standard of care as embodied in the *Bolam* test. Reasonable forseeability is objective in the sense that it is about reasonableness; it is also subjective in the sense that it is about forseeability which is itself contextual and therefore dependant on the patient's value system and the doctor's knowledge of that value system.[7]

Medical knowledge has become very important to the law in answering the question of factual causation and in answering questions of both moral and physical responsibility. This task is accomplished with the help of medical evidence. The determination of factual causation is no easy task for the court because it deals with the probable actions of the plaintiff.[8] In the medical field, pre-existing conditions,[9] as well as consequent and subsequent developments, can obscure the factual picture. The outcomes of disclosure and some medical product liability cases turn on the acceptance of the expert evidence on the issue in dispute, by the court's trier of fact. It also turns on the *basis* of the court's finding on causation.

In the law of torts or delict, causation is a necessary element of the claim. It is common ground in all the legal systems under discussion that the plaintiff in personal injury cases bears the burden of establishing on balance of probabilities that the defendant's alleged negligence

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[6] See Thomson. *Delictual Liability*. p117.
[7] This will be discussed more fully in Chapter 5.
[8] This is not unique to this area of law and crops up *inter alia* when dealing with safety around the workplace.
[9] Such a problem would pose itself in the case of iatrogenic injuries. For example, in operations on areas of the body where high concentrations of bacteria occur naturally (an appendectomy, for example), where sepsis results it is difficult to determine whether sepsis was caused by inadequate pre-operative sterilisation procedures or as by the bacteria naturally occurring in the appendix. Similarly, it may at times be difficult to distinguish as a matter of fact, between the natural progression of a disease and an extraneous causal agent.

was a proximate cause of, or materially contributed to, the injury to the plaintiff.[10]

The issue in this thesis is the supply to the patient-plaintiff of what we can now call material information on the medical procedure in question. This plaintiff must then prove that the defendant's negligent omission to supply that information caused the injury suffered. To establish this, the plaintiff is required first to satisfy the *but for* test, that is to prove that had he been informed of the inherent risk in or alternative to a medical procedure, he would not have undergone the procedure at that time and hence would have avoided the injury associated with the inherent risk. As we will see, the issue of and test for causation differs among jurisdictions. It is these tests which will be juxtaposed in this chapter. Alternatively, in the law of torts or delict, 'material contribution' may establish causation.[11]

Having established that a duty of care in fact existed in the circumstances of the case, and that it included provision of information on the risk which eventuated, there should be established a sufficiently proximate link between this negligent omission of the defendant and the loss suffered by the plaintiff. The causation inquiry is in two stages. Factual or proximate causation is established first as a question of medical fact which asks whether the treatment could possibly have caused the injury complained of. Thereafter, and given an answer in the affirmative, the court asks, 'would the plaintiff have suffered the loss or injury which he in fact suffered, but for the act or omission of the defendant?'

If the answer to the *sine qua non* question is 'yes', then the plaintiff fails to establish a sufficiently proximate link. More specifically, the question is not whether a given event in fact occurred, but rather whether that event is 'sufficiently like the standard case [of such events] so as to be classified alongside it for legal purposes.'[12] If the answer is 'no', then the court goes on to consider legal causation. This is where the issue becomes controversial because it is at that stage of the inquiry that policy considerations come into play.[13] It is in the causation inquiry as a whole that different tests and policies are employed to different effects. This is important because not only is there a difference among jurisdictions; there is a difference in respect of the

[10] Except in cases where the maxim *res ipsa loquitur* applies or the example of South Africa, where the defence of *volenti non fit iniuria* is available.
[11] See the discussion of the *McGhee* principle in 4.3. and 6.2.2.
[12] Hart & Honoré. 111.

tests for negligence *simpliciter* and in respect of disclosure cases – though not in the case of Britain.

The term by which the inquiry is known is not taken literally. In fact it is questionable whether legal causation has anything to do with 'relations between particular events in time and place',[14] because the main objective of the inquiry is to ensure that at its conclusion the victim is fully compensated. Legal causation itself has nothing to do with cause and effect, yet remains an inseparable facet of a dual causation inquiry. It has to do with proximity and policy and with the desire to ascribe blame and responsibility and to exhort explanation following medical mishap.

The issue of blame or culpability is an important one and, ideologically, this is another reason why the causation inquiry is an important one. If a medical practitioner can be said to have factually and legally caused a particular injury due to their negligent omission, this will render that practitioner responsible for that person's injury. Vicarious liability aside, it is this which injured patients would seek: someone to shoulder the responsibility. This gains enhanced importance in our present culture of blame because to say that a doctor caused someone to suffer an injury which was itself a risk inherent in the medical procedure undertaken, implies a very weighty value judgement. The court would, in effect, be isolating a single non-event as blameworthy and, in that isolation, ignoring the many other factors which went into the patient's decision.[15] This is ironic in view of the application of the test for causation which - if it be modified-objective in the Canadian sense, or even if it be subjective in the Australian sense – which requires the court and the medical practitioner to take these factors (such as lifestyle, value system, etc.) into account.

In negligence matters, policy has two main opportunities to express itself.[16] The first is the inquiry into whether a duty of care exists in a given set of circumstances and relations – and indeed the matter of the test for the standard of that care. The second concerns the interests of

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[13] For a full treatment of this topic, see B S Markesinis & S F Deakin *Tort Law* (3 Ed.). 1995. Oxford. New York. 163 - 192.

[14] Ibid. 164 .

[15] For a discussion of blameworthiness and the relation between criminal and civil law in this respect, see Padfield, Nicola. 'Clean Water and Muddy Causation: is Causation a Question of Law or Fact, of Just a Way of Allocating Blame?' [1995] *Criminal Law Review* 683.

the plaintiff and the extent to which these interests are protected by legal tests for materiality and causation. It is at that point that the scope of legal responsibility is guided by policy. Legal policy is both made and guided within the inquiry into causation because the two facets are amalgamated.[17] Rules on the burden of proof make a matter more or less easy for the plaintiff to prove, and these rules can be manipulated. An example of such judicial manipulation was seen in the discussion of *materiality* in this thesis.[18]

Limits on liability imposed by the rules governing causation are matters of judicial policy. An example of this is cited by Hart and Honoré as the *McGhee* principle[19] in which a decision was made on the loss of chance doctrine in the law of delict based on policy and using causation rules. Legal policy is a question for the court rather than for the jury or the finder of fact. It comprises a question of whether the method of inquiry into causation is able to protect the interests of the plaintiff and it is predicated on whether, in the view of the court, those interests are worth protecting.

The inquiry into proximate causation is an example of such a court-imposed limitation on liability. Proximity has little to do with factual causation and so for reasons of policy falls under the inquiry into legal causation. Causal principles, then, are supplemented by judicial policy in order not to impose too great a burden on defendants. Hart and Honoré argue that these questions are essentially non-causal and are in fact fit for consideration by a jury.[20] This is considered to be the correct view on the ground that it would remove from the judiciary an existing hegemony of approach which would serve the purpose of the inquiry into legal causation by benefiting the plaintiff. At the same time it would allow more scope for reform in the law.

Factual causation, on the other hand, is not particularly controversial in disclosure cases because it is answered on the basis of medical evidence in the United Kingdom.[21] Difficulties arise where there is more than one possible factual cause of injury, which is why the matter is

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[16] Although, as this thesis has pointed out, many smaller policy 'junctions' exist (Cf. 1.6., & 3.4., as well as 6.1).
[17] Cf. 3.3. on the dovetailing of the test for materiality with that for legal causation.
[18] Cf. 3.3.
[19] Hart & Honoré 104. *McGhee v National Coal Board* 1973 SLT 14, [1973] 1 WLR 1.
[20] 307.
[21] Which can itself be controversial, however. Cf. 5.5.4.

determined on balance of probabilities rather than on actual possibility.[22] Yet controversy exists insofar as there is an 'air of arbitrariness' in ascertaining probability of greater than fifty per cent.[23]

The causation inquiry as a whole remains controversial, because that is one of the points at which different policies of jurisdictions become apparent.[24] It is at that point that policy is able to be made through objective or subjective tests which produce different judicial decisions because policy is, after all, another term for selective reasoning. It is therefore the tests for hypothetical[25] causation which deserve consideration here, particularly in respect of which parties' values are taken into account to a greater degree through the form of testing used. Once again, it is instructive to begin with the positions in some American jurisdictions.

4.2. AMERICA

Because the so-called doctrine of informed consent is an American product and because causation is a pivotal stage within disclosure cases from a policy point of view, it is important to consider the position on causation in that country. The American plaintiff still bears the burden of proof of establishing the *prima facie* elements of the cause and so must establish that the defendant's negligence was a proximate cause of the injury actually suffered.

Canterbury v Spence[26] remains the American case on informed consent which is most cited within the Commonwealth and in the literature on the topic. In that case it was held that once it has been established that there was a duty to disclose a certain risk, and that the practitioner negligently omitted to do so, the 'unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without

[22] See *Wilsher v Essex Area Health Authority* [1988] AC 1074.
[23] Markesinis & Deakin. 170. This also has to do with what was argued in Chapter 2 on medical thinking. As a science, medicine is empirical; an expert witness, turning the learning of experience into probabilities for the benefit of the court and without the benefit of personal knowledge of the plaintiff, is a very inexact science.
[24] Another being the degree acceptance or rejection of *Bolam*-style standards on the matter of informed consent outlined in Chapters 3 and 6.
[25] It will be hypothetical because the result will depend on the evidence-led conclusion drawn by the court as to what the plaintiff would have done had he or she had the information which was lacking.
[26] 464 F.2d 772 (1972).

consequence.'[27] This is because of the tort principle that negligence unrelated to injury is not actionable.

There must be an injury and this must be caused by the practitioner's omission. It was established in *Canterbury v Spence* that a 'causal connection exists when, and only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it.'[28] It was held that the rationale behind this is that the disclosure rule has the purpose of allowing the patient to avoid adverse consequences if in his estimation the risk of those consequences materialising is too great.

The court went on to consider the subjective test for legal causation, which asks what *this* patient would have decided had the information been given. Judge Robinson argued that linking a conclusion on factual causation with the plaintiff's testimony in this matter rendered the question hypothetical. He preferred an objective test, holding that the subjective approach 'places the physician in jeopardy of the patient's hindsight and bitterness.'[29] He opted for solving the issue in terms of what a prudent person in the plaintiff's position would have decided if suitably informed of all perils bearing significance.'[30] For this the plaintiff's testimony is relevant, but not dispositive.

That said, there has been modification of this standard in some jurisdictions: for example, in *McPherson v Ellis*,[31] the Supreme Court of North Carolina used a subjective test. Having agreed that the problem with subjective testing in proximate causation lay with hindsight, Mitchell J said, 'The detriments of the objective standard are more severe, however.'[32] This is because, as he put it, '[t]he right to base one's consent on proper information is effectively vitiated for those with fears, apprehensions, religious beliefs, or superstitions outside the mainstream of society.'[33] Accordingly, he held the subjective test to be the proper standard.

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[27] 790 [30]. An exception, perhaps, might be a sterilisation operation in which refusing to undergo the operation on the ground of the risk of failure would be counter-productive because the very purpose of the surgery would be ignored.
[28] 790 [31].
[29] 790 - 791 [31].
[30] 791 [32].
[31] 287 SE 892 (NC 1982).
[32] 897.
[33] Ibid.

More recently, in *Bernard v Char*[34] the Appeal Court of Hawaii discussed the matter more fully, noting that 'a divergence of views exists' on the standard to determine proximate causation.[35] Judge Wanatabe cited with approval another Hawaiian case, observing that the court in *Leyson v Steuermann*[36] had 'opted to apply a "modified objective standard" that determines causation "from the viewpoint of the actual patient acting rationally and reasonably".' Accordingly, the Hawaiian judiciary adopted a compromise standard, which placed that jurisdiction in the same position as that adopted by the Canadian judiciary. We will see that there is as little uniformity among American jurisdictions as there is among the others being considered.

4.3. ENGLAND AND SUBJECTIVITY

The issue as settled in England is the starting point taken by other Commonwealth jurisdictions. It is fitting to start in that jurisdiction in which the test for causation in tort law has been held to be and remains subjective and individualised.[37] *Bolam v Friern Hospital Management Committee*[38] and *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*[39] together remain the leading cases on consent in England.

Bolam concerned alleged negligent administration of treatment as well as failure to warn a psychiatric patient of the risk of fracture involved in electro-convulsive therapy for depressive illness. Having found that the defendant was not negligent in omitting to give a warning, McNair J did not need to consider the issue of causation. Prior to this finding, however, he had asked the jury, 'Suppose you come to the conclusion that proper practice

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[34] 903 P.2d 676 (1995) Haw. App.

[35] 383. Watanabe J cited the following cases as critical of the subjective standard: *Sard v Hardy* Md., 449, 379 A.2d, 1025 (1977) (quoting *Canterbury v Spence*, 464 F.2d (772), 790-91) and *Hartke v McKelway* 464 U.S. 983, 78 L. Ed. 2d 360, 104 S. Ct. 425 (1983). As having adopted the subjective standard, the judge cited *Hammer v Mount Sinai Hosp.* 220 Conn. 933, 599 A.2d 384 (1991), *McPherson v Ellis*, 305 N.C. 266, 287 S.E.2d 892 (1982) and *Scott v Bradford* 606 P.2d 554 (Okla. 1979).

[36] Haw. App. at 517 n.10, 705 P.2d at 47.

[37] But consider the arguments in 6.3. and later in this section on the introduction of more objectivity. Consider, too, Tony Honoré, 'Causation and Disclosure of Medical Risks', (1998) 114 *Law Quarterly Review* 54 in which Honoré argues that all jurisdictions [covered by this thesis and with the exception of some American Jurisdictions] other than Canada adopt a subjective test for causation. With respect, it is submitted that that his view is incorrect, though courts do not state the issue overtly. Cf. 6.3.

[38] [1957] 2 All ER 118, [1957] 1 WLR 582.

[39] [1985] 1 All ER 643 HL, [1984] 2 WLR 778; [1984] AC 871.

requires some warning to be given, would it have made any difference?'[40] Significantly, he went on to assert that only the plaintiff could answer that question.[41] The jury was directed that, 'in order to recover damages for failure to give warning the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment.'[42]

Hirst, J in *Hills v Potter*, did not need to consider causation either, because he had already held that the defendant had not been negligent; yet he did so 'for the sake of completeness.'[43] Having drawn on *Reibl v Hughes* extensively in his consideration of the appropriate form of action he suggested that the test would be objective and that on that test the plaintiff would have failed. Not only were these comments *obiter*, but this was not the position adopted by the judiciary when they were to consider the matter of causation when it mattered.

Sidaway remains the most important English decision on informed consent, yet the court was silent on causation because the case turned on whether or not English law should adopt the doctrine of informed consent. Having decided that it should not, a discussion of causation was not necessary because it was held that the standard of care did not include obtaining informed consent, and that on the *Bolam* standard, the duty of care had not been breached. This case did consider the legal positioning of the doctrine and found that its correct place is in the law of torts; specifically in negligence.[44] Lord Scarman noted, 'One point is clear, however. If failure to warn of a risk is actionable in English law, it must be because it is in the circumstances a breach of the duty of care: in other words, the doctor must be shown to be negligent.'[45]

Had the case not been concerned with the duty of care and the adoption of the doctrine of informed consent, or indeed had the House adopted that doctrine, the House of Lords would have had to consider causation. Causation is material in the United Kingdom only after it has been established that the relationship between the litigating parties was sufficiently proximate to

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[40] [1957] 2 All ER 118, 124H.
[41] This approach has changed radically in other jurisdictions and is no longer supported in England either. Cf. 6.2.
[42] [1957] 2 All ER 118, 118I.
[43] [1983] 3 All ER 716, 728*f-g*.
[44] Consider the discussion of the law in *Sidaway* [1985] 1 AC 871, 883 per Lord Scarman.
[45] *Sidaway* [1985] 1 AC 871, 885E per Lord Scarman.

found a duty of care, and that that duty was breached by the defendant. At that point the court is able to make or enforce policy at the level of causation. In negligence terms, this means that the plaintiff would have to prove that the defendant's act or omission was causal as a *conditio sine qua non* in terms of the test adopted by the court. The standard on the *Bolam* test and informed consent as set out in *Sidaway* remains the standard in England, although some modification has been noted at the level of causation.[46]

Hotson v East Berkshire Area Health Authority[47] considered the matter of whether the loss of a chance was an issue of causation or quantum. Lord Bridge held that the applicable legal principle here is:

> 'Unless a plaintiff has proved on balance of probabilities that the delayed treatment was at least a material contributory cause of the [injury] he failed on the issue of causation and no question of quantification could arise.'[48] He went on to confirm that, 'This amounts to a finding of fact.'[49]

The matter of loss of chance will be reconsidered in greater detail in Chapter 6 when discussion turns to possible routes towards British adoption of the principles embodied in the doctrine of informed consent. In that context, it will be suggested that the loss of chance is the chance to engage an alternative physician. This argument will be based on some of the extents to which the doctrine has been taken in America. It is for that reason, and in the interests of completeness, that loss of chance is mentioned in a chapter on causation. However, given that the court in *Hotson* rejected loss of chance as a form of recovery in medical negligence cases, it is considered unlikely that courts would adopt it as part of a doctrine which does not form part of the law of the United Kingdom. That said, in *Goorkani*, the pursuer, having lost his case on its merits, was awarded damages for loss of the opportunity to become accustomed to the sterility which was an inherent risk in the treatment to which he had consented. In the informed consent scenario, the patient 'loses the opportunity to escape the full effects of his illness'[50] because an inherent risk caused him injury. The argument is the following: if the court in *Hotson* left the issue open as regards the possibility of recovering damages in medical negligence cases for loss of chance, and given the judgement in *Goorkani* and the argument which will be presented in Chapter 6 which asserts that the American extremes are a form of

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[46] Cf. Chapter 6.
[47] [1987] 2 All ER 909.
[48] 913e.
[49] 913g.
[50] Marc Staunch. 'Causation, Risk, and loss of Chance in Medical Negligence.' (1997) 17 *Oxford Journal of Legal Studies* 205, 206.

lost chance, it is possible that loss of chance as a causation issue, could come to the aid of the plaintiff.

If one is considering the loss of chance to engage a physician who has a better track record, the *Kokemoor* omission to inform of the physician's track record would be considered to be material information only within the confines of the doctrine of informed consent, once adopted.[51] Thereafter, one might argue that the less experienced surgeon performing the operation, materially increased the chances of suffering an inherent risk. The plaintiff would argue that had they known of both the inherent risk and the surgeon's inexperience, they would not have consented to the procedure and would hence not have suffered the injury.

Other than loss of chance and *sine qua non*, another way of proving causation is by establishing material contribution. Putting any single event or non event forward as a cause in law is tantamount to an exclusion of other factors such as the patient's lifestyle, which is why, as Staunch suggests, one ought to begin to consider a particular non-event as a cause if it is a necessary element in a set of events which together comprise the cause of an injury.[52] The twin tests of balance of probabilities and material contribution entail the mixing of questions of law with causal questions of fact, must precede the question of what action the plaintiff would have taken in the event of having been informed. Similarly, Lord Mackay of Clashfern, drawing on the *McGhee* principle,[53] stressed the need to establish a relationship between the injury suffered and the defendant's omission.

In *McGhee*, the court found that the omission to provide washing facilities materially contributed to the dermatitis suffered by the plaintiff. That omission was part of a set of events such as the fact that the plaintiff had to cycle home, so allowing the brick dust (a further causal element) to remain on his skin and lead to dermatitis. The omission to inform of a risk can be seen as having made a similar material contribution because, along with other factors which have to do with the plaintiff's lifestyle, values and pre-existing medical condition, it would have appeared to the patient that treatment was an indicated option. In that sense, the doctor's

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[51] See discussion of *Johnson v Kokemoor* 199 Wis. 2d 615, 545 N.W.2d 495 (1996). In 6.2.2.
[52] See Marc Staunch. 'Causation, Risk, and loss of Chance in Medical Negligence.' (1997) 17 *Oxford Journal of Legal Studies* 205.
[53] Established by *McGhee v National Coal Board* [1972] 3 All ER 1008, [1973] 1 WLR 1. Lord Mackay drew on this principle despite the fact that neither party relied on the decision.

omission may be said to be a cause if it was both a necessary element among a set of other factors for the harmful effect.

In the final analysis of the judgement, one puts the non-event forward as a cause and, in that act, isolates it from other factors. This becomes a policy question – albeit in subtext - and a matter of the allocation of blame and responsibility. In Britain, this effect is minimised by the application of the *Bolam* test because it is the medical practitioner's view of materiality which carries more weight in courts than the injured patient's view. This means that those 'other factors' are not recognised as being as important as they are seen to be in Canada, Australia and South Africa.[54]

Considering the *Bolam* test in the context of materiality and causation tends to beg the question of the applicability of Bolam to the causation inquiry. The Court of Appeal (and later the House of Lords) considered this in *Bolitho and Others v City and Hackney Health Authority*.[55] The defence admitted negligently omitting to attend and to intubate a child suffering from respiratory blockage insofar as the paediatrician had not responded to a pager call from the ward sister, but disputed the matter on causation, arguing that the case turned on what the reasonable doctor would have done in the situation.

This argument was based on the fact that intubation would, on the evidence, have saved the patient. By extension the omission was a proximate cause of the injury because but for those material omissions the plaintiff would not have been harmed. The argument was accepted by Farquharson LJ on behalf of the Court of Appeal who held that '[w]hether Dr Horn's failure to appear would have made any difference depended on what she would have done had she been present.'[56] This is because her actions would have determined the chain of causation.

Lord Justice Dillon supported the *Maynard*[57] approach in this case, seeing it as 'essentially [a question] of causation.'[58] In the Court of Appeal Lord Justice Simon Brown threw a cat among the pigeons in his dissenting judgement in *Bolitho*. Considering causation,

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[54] Thought in the next chapter this view will be challenged.
[55] [1993] 4 Med LR 380, 39 BMLR 1.
[56] 386.
[57] *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634.
[58] 391-392.

he noted that the court at first instance used divergent tests at separate parts of the judgement.[59] He argued that the matter was resolved according to what he termed the '*Maynard* test'[60] which lies in the answer as to whether a senior Registrar of ordinary skill would have intubated the patient. He argued that what he termed the 'probability test' ought to be employed; that is that it was more probable than not that had Dr Horn attended, the action she would have taken would have averted the injury.

Simon Brown LJ argued that the contextual basis for the *Maynard* test is *Bolam* and *Hunter v Hanley* and that that in itself makes it inappropriate to a discussion of causation. He argued that '[in this instance] no doctor ever took a decision whether to intubate' and so it was not a question of preferring one body of respectable medical opinion over another. Simon Brown LJ cited *McWilliams v Sir William Arrow & Co. Ltd*,[61] in which Lord Hudson had said, 'it rarely matters where the onus originally lay, the question is which way the balance of probabilities has come to rest.' As Puxon argued,

> 'It is worth noting that the *Maynard* principle - "negligence is not established by preferring one responsible body of professional opinion to another" - only applies to treatment and *diagnosis*, not causation.' [62]

This was not an argument which was to appeal to the House of Lords.

The central importance of *Bolitho* concerns causation on the level of hypothesis; it is this that makes the comparison between *Bolitho* and the disclosure cases an appropriate one. On that point the House of Lords addressed two questions: *would the doctor have intubated* and *was such failure to intubate contrary to accepted medical practice*.[63] The second question can only be broached if the first is answered in the negative.

It was not disputed that, as a question of fact, the failure to intubate led to the patient's death. The court confirmed that the *Bolam* test had no part to play in answering the first

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[59] 387.

[60] From the judgement in *Maynard* the grounds for this test lie in Lord Scarman's judgement in which he held that 'negligence is not established by preferring one respectable body of professional opinion over another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality if he be a specialist) is necessary.'

[61] [1962] 1 WLR 295.

[62] [1994] 5 Med LR 364. The reader is referred to the words of Lord Scarman in *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635.

[63] *Bolitho(administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority* (1997) HL, 39 BMLR 1, 6-7; [1997] 4 All ER 771 HL, 776-7.

question. There was no question in the evidence of what the consultant paediatrician in fact did; but it was essential to her case to argue that she would *not* have intubated had she attended.[64] Determination of what would have happened had *someone* attended the patient therefore fell to be resolved on the basis of hypothesis; to so hypothesise the court used the *Bolam* test.

Such a situation can arise only in cases dealing with omissions. This is because the court did not, within the inquiry into causation, ask whether the treatment was one among several alternatives that would have been rightly employed by the reasonable medical practitioner. The court asked whether an omission would have been made by the reasonable consultant and then applied that answer to their test for causation.

This means that the case did not concern an assessment of the relative risks and benefits within the standard of care as much it considered that assessment within the causation inquiry. A common practice can be condemned as unacceptable, but that has more to do with credibility and internal consistency of evidence than Denning-style judging. The medical profession still polices itself subject to judicial sanction; we must bear in mind that the defendant won precisely *by* applying a medical standard to causation which is, in fact, the controversial aspect of the judgement.

The decision in *Bolitho* will be closely monitored - less for what it held on the matter of expert evidence than for its consideration of causation and the applicability of the *Bolam* test at that stage of the judicial inquiry. The danger in this case is hybridisation: mixing the *Bolam* test with tests for causation in a test which requires the plaintiff to prove that had the omission not occurred, what would have happened in its place would not only have been what the reasonable practitioner in that situation would have done, but that this reasonable practitioner's actions would have prevented the injury to the plaintiff. This is viewing the argument from the opposite angle: ordinarily one has an act or omission which falls to be assessed by the standards of the reasonably competent practitioner in the situation. Now we have an injury from which we are required to determine what the reasonably competent practitioner in the situation would have done prior to it and *from that* we may assess whether negligence has occurred.

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[64] The analogy here is that in disclosure cases the defence would argue that the reasonable medical practitioner would not have informed the patient of a particular inherent risk.

That the *Bolam* test was formerly inapplicable to the causation inquiry follows a conclusion which was anticipated in *Sidaway*.[65] A responsible body of opinion supported the defendant and the court was not entitled to prefer one body of respectable opinion over the other unless one opinion was found to be *Wednesbury* unreasonable. The application of *Bolam* is not usually applicable to the issue of causation, being 'too simplistic an approach when it comes to causation.'[66] Legal causation is not a matter to be assessed by weight of expert opinion. This sort of giving way to medical evidence can be ascribed to a tendency of the courts rather than to the weight of the evidence because, as Puxon noted, it was 'certainly not encouraged by *Sidaway*.'[67]

From the preceding discussion, it is arguable that Puxon has been proven wrong by the House of Lords judgement in *Bolitho*. *Bolam*, then *is* applicable to the causation inquiry because causation is hypothetical and *Bolam* is a useful test as a basis on which to hypothesise. On the basis of this argument on omission liability, one can speculate[68] on what the effect of this might be on disclosure cases. For now it must be borne in mind that *Bolitho* was a case which did not concern the informed consent scenario, but it remains important from the point of view of the use of the *Bolam* test at the level of the inquiry into hypothetical causation. It is therefore important to consider some English decisions on informed consent, which did broach the question of causation.

Smith v Tunbridge Wells Health Authority[69] was an informed consent case in which the surgeon had allegedly failed to explain sufficiently clearly the risk of impotence arising out of the so-called Wells operation. Here the plaintiff succeeded in 'applying the *Bolam* test as elucidated in *Sidaway*,'[70] so was obliged to prove causation. Morland J held that on balance of probabilities had the risk been disclosed, the plaintiff would have refused surgery. This was

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[65] Consider *Loveday v Renton and Wellcome Foundation Ltd* [1990] 1 MLR 117 in Lord Justice Stewart-Smith held that 'it was fundamental to the *Bolam* test that if a doctor acted in accordance with the practice and opinion of a respectable and responsible body of medical opinion, he was not guilty of negligence, even if another respectable and responsible body of opinion held different views; such a test could not, therefore, apply to causation.'

[66] Comment by Margaret Puxon QC. [1993] 4 Med LR 393.

[67] Ibid. This is largely irrelevant in Australia and Canada; and even more so in South Africa where the issue is treated as one of consent rather than of negligence, even although causation remains an essential element of the law of delict.

[68] As will be done in 6.3.

[69] [1994] 5 Med LR 334

decided on the grounds that the plaintiff was at the material time 28 years of age, happily married and had by that stage suffered with his condition for eight years. The decision indicates that the test in England is a subjective one.

A similar case to *Smith v Tunbridge Wells*, and reported directly after it, is *McAllister v Lewisham.*[71] An informed consent case which considered *Bolam* test, it concerned a consultant neurosurgeon's allegedly negligent failure to inform the plaintiff of the risk of sensory deficit beyond her leg (the area affected prior to surgery) as a result of brain surgery. Fortunately, this case did not make a hybrid from causation and *Bolam.* In his judgement Rougier J said, 'Of one thing however I feel confident and that is that Mrs McAllister would have postponed the operation until such time as she had established herself in the new job which was so important to her.'[72]

Mrs McAllister would under tort law have been required to establish just that, but the judge in this case asked somewhat rhetorically, 'Is it possible to say, on a balance of probability, what her decision would have been?'[73] He concluded that the plaintiff's own 'reluctan[ce] to hypothesise' on the basis of hindsight did not preclude a judge from so hypothesising. He also concluded that the plaintiff would *probably* 'have continued to decline the operation.'[74] Again, the test for causation appears to have been subjective. Rougier J cited as reasons for coming to this view, inter alia, the plaintiff's personality ('a sensible and independent-minded woman ... who could be expected to make a rational decision') and her job and the independence it gave her. Most importantly, Rougier J held that,

> 'given time to think, and in view of the fact that this was one of the most important decisions of her life, she would, as she thought herself, have taken a second opinion, and for the reasons I have already expressed, it is far more likely in my opinion that that second opinion would have been much more keenly aware of the dangers of operating and would, in whatever way it was expressed, have not been in favour of the operation.'[75]

This decision effectively held that there was a causal connection between the defendant's omission and the injury suffered by the plaintiff - an injury the risk of which was

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[70] 339. Cf. Chapters 3 and 6. This case indicates an abandonment of the pure *Bolam* principle (see Puxon's comment after this case).
[71] *McAllister v Lewisham* [1994] 5 Med LR 343.
[72] 353.
[73] Ibid.
[74] Ibid. Own emphasis.

inherent in the procedure. Notably, in the face of the plaintiff's inability to answer, Rougier J considered himself able to assert that with the information which was lacking the plaintiff would have sought a second opinion, so delaying the surgery and avoiding injury. Taken together and considering the issue of causation, *Smith v Tunbridge Wells* and *McAllister v Lewisham* indicate a greater judicial sensitivity to the patient.

Newell and Newell v Goldenberg[76] is an all too common example of a sterilisation operation (vasectomy) about which the plaintiff was allegedly insufficiently acquainted with the risk of failure. The defendant conceded that he did not give warning of a 1:2,300 chance of recanalisation of the vas, but argued that this failure was consistent with the practice of a responsible body of respectable medical opinion.

Mantell J held that that body of medical opinion was 'neither responsible nor respectable', hence the omission was negligent. He said, 'in failing to warn of the risk that Mr Newell might resume fertility the defendant fell below the standard required and was in breach of duty.'[77] Under the causation head, he went on to say,

> 'It follows that the plaintiffs, or at least one of them, must succeed, but to what extent? That turns on the resolution of ...[a] more difficult question. What would the Newells have done had they been told [of the risk]?'[78]

The plaintiffs had given evidence that had they known of the risk, Mrs Newell would also have undergone a sterilisation - which she had in fact done after the birth of the child conceived following Mr Newell's vasectomy. He held that this action was taken and this decision made with the advantage of hindsight. He accepted the word of one expert that he knew of no case where such a decision had been taken once a patient had been warned of the risks involved, of a second that he rarely advised female sterilisation and of a third that he never advised simultaneous sterilisation of both partners.

These factors, together with the plaintiffs' decision not to terminate the pregnancy, lead to the conclusion that had they been fully advised as the duty of care demanded in this instance, they would still have accepted the risk without Mrs Newell having surgery - which would have

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[75] 353.
[76] [1995] 6 Med LR 371.
[77] 374.
[78] Ibid.

been medically contraindicated.[79] In this case the test seems to be more objective, yet able to take the particular plaintiff into account. What is apparent from this case and from *McAllister v Lewisham* is that the courts do not take what the plaintiff has to say at face value; so showing a similar skepticism of hindsight and proclivity for *apparent*-subjective testing to that of their Canadian counterparts.[80]

The final English case for discussion here is *Lybert v Warrington Health Authority*.[81] It also considered a failed sterilisation operation; this time on a woman. The plaintiff proved that there was a duty to inform and that this duty had not been fulfilled.[82] The onus and the test for causation remained as they had been in *Newell and Newell v Goldenberg*. According to that test, Lord Justice Otton held that 'there was an inherent likelihood that the plaintiff and her husband would have heeded a proper warning; conversely, there was an inherent unliklihood that they would have ignored or forgotten had such a warning been given.'[83] Here Otton LJ accepted the evidence of one expert witness that 'in normal circumstances it would be intrinsically improbable to use contraception in addition to sterilisation.' The judge quoted with approval the judge at first instance, considering the following finding unassailable:

> 'I have come to the firm conclusion on the balance of probabilities, but to a degree going beyond the mere balance, that the plaintiff would not, if she had been properly counselled and warned before or after the operation, have engaged thereafter in unprotected sex.'[84]

The plaintiff was thus allowed damages in respect of the birth of her child following failed sterilisation.

Otton LJ held it to be intrinsically improbable that a couple would use contraceptive methods additional to sterilisation in normal circumstances. However, he also held that these did not constitute normal circumstances[85] and were 'sufficient to tilt the balance of inherent

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[79] This is similar to the fact situation in *Arndt v Smith.*

[80] This is important when considering the erosion of the *Bolam* test (in Chapter 6) and the direction that erosion is likely to take. Cf. 6.3.

[81] [1996] 7 Med LR 71.

[82] By the contents of the signed consent form.

[83] [1996] 7 Med LR 71, 72.

[84] Ibid., 74, Col. ii.

[85] The plaintiff's previous history of three caesarean section births, the problem of a waiting list for the procedure and the advice (having reached the top of that list and also having fallen pregnant), that it was not possible to perform a hysterectomy during a caesarean section, as well as the fact that a fourth caesarean section would have been her probable lot had she fallen pregnant a fourth time (which she indeed did).

probability in the opposite direction.'[86] Here we see the court taking on trust the evidence of the plaintiff, yet formulating this and other material in terms of 'inherent *un*liklihood' and 'inherent *im*probability'.

In summary, the law in England maintains the *Bolam* test and so does not adopt the doctrine of informed consent. Similarly, and in accordance with the law of torts, courts maintain a subjective test for causation, by taking the views of the patient into account. The need to alter or employ any test for causation does not arise until the court finds in favour of the plaintiff on the standard of care. At that point slightly more objectivity is needed in order to be neither unduly harsh on the medical profession nor to give way to the hindsight of the patient. This will become apparent when considering the Canadian test and be equally apparent, though from a different perspective, when considering the Australian test. As discussed earlier, there seems to be evidence for this in *Newell and Newell v Goldenberg* and *McAllister v Lewisham.*

If English courts adopt the doctrine of informed consent and include disclosure of all material risks within the doctor's duty of care, then the law of medical negligence based on consent could become as patient-centric as that of Australia unless a more objective test for causation were adopted. This is because, as Chief Justice Laskin said in *Reibl v Hughes* in Canada,

> 'Since liability rests only in negligence, in a failure to disclose material risks, the issue of causation would be in the patient's hands on a subjective test, and would, if his evidence were accepted, result inevitably in liability unless, of course, there was a finding that there was no breach of the duty of disclosure.'[87]

That is why England is holding on to the *Bolam* test as articulated in *Sidaway.* It is also why such decisions should be carefully monitored in the future because of the slippage towards a Canadian form of testing noted in this section.[88]

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[86] 75.
[87] (1980) 114 DLR. (3d) 1, 16.
[88] And which will be further teased out in 5.4.4. & 6.3.

4.4. SCOTLAND

Cosgrove v Lothian Health Board and Another[89] followed *Hunter v Hanley* and *Sidaway* in finding that there was no duty on a gynaecologist who was to perform a laparoscopic sterilisation on the pursuer, to point out alleged additional risks of bowel damage in the case of a patient who was obese. Accordingly the case failed because no negligence was found. Counsel's 'insurance policy' was the submission, which was accepted by the court,[90] that had the pursuer established her case, that case would fail on causation. Lord Milligan held that even if informed of an increased risk of bowel damage due to obesity from 0.18% to 0.36%, it was very unlikely that she would have refused the operation. However, according to *Cosgrove*, the test for causation remains only apparently subjective. This was held despite her evidence to the contrary, which shows the same skepticism of hindsight as that shown in *Newell* and in *McAllister* in England.

The *volenti* defence, which exists in the law of delict, is a defence which comes in at the point of proof of causation. The chain of causation will have been broken by the patient's voluntary assumption of risk. It has already been noted what test the court would apply in the context of informed consent to medical procedures,[91] yet this defence has not been held to apply in the Scots law on informed consent.[92]

In disclosure cases the court will not confront the matter of causation until it is accepted that the medical profession accepts the doctrine of informed consent, or that the duty of care included provision of information on the material risk. In Scotland this depends on the opinion of a respectable body of opinion. That this is the case is clear from *Gordon v Wilson*.[93]

In *Moyes v Lothian Health Board* the Outer House found that a neurologist who failed to warn of the risk of stroke following an angiography procedure was not negligent on the *Hunter* standard. The court thus had no need to consider causation. Even so, in Lord Caplan's

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[89] Court of Session: Outer House (1990), 9 March 1990, Unreported, Lexis, 1990 GWD 15-839.
[90] Another matter unnecessarily covered in the judgement of Lord Milligan was that of quantum: he held that had the pursuer established her case, damages to the tune of £4,500 would have been awarded.
[91] Cf. Chapter 3.
[92] The position in Scots law should be considered in conjunction with what was said in 3.3 on materiality and the test laid down in *Hunter v Hanley* and in comparison to South Africa on *volenti* in 3.2.2.3., 4.7. & 6.4.
[93] 1992 SLT 849, 852F & 852L-853C. Cf. 3.3.1.

opinion, had the failure to warn been found to be negligent, the outcome of the case would have been different only if the patient would have refused to undergo the operation had she known of the risk.[94] A similarly subjective test was used in *Goorkani v Tayside Health Board.* In that case the plaintiff established negligence in the failure to warn of the risk of infertility from a drug used to treat an eye condition. However, it was held that even in the presence of such information, the pursuer would have taken that risk because the drug saved his sight.[95]

4.5. CANADA: MODIFIED OBJECTIVITY

The causation inquiry in Canadian common law begins with the English law of torts in which a subjective test was established. This test was comprehensively reanalysed and modified in the context of informed consent in *Reibl v Hughes*[96] which is the first major port of call of this inquiry and which remains the benchmark case on informed consent in Canada.[97]

Before that case, the Supreme Court of Canada dealt with the matter of informed consent in *Hopp v Lepp.*[98] That case demonstrated that the first issue with which the court deals is the duty of care. If the court holds that there was in the circumstances of the case a duty of disclosure, the court may consider factual and then legal causation. That these are different issues is clear from the fact that Laskin CJC quoted the trial judge, concerning the inherent risks of the procedure, as having said, '[they] need not concern matters which directly cause the ultimate damage if they are of a nature which might influence the judgement on which consent is based.'[99]

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[94] 447F-K.

[95] [1991] 3 Med LR 33, 38 (Col. ii). The purser was, however, awarded damages for the loss of the opportunity to become accustomed to his impending infertility.

[96] The facts of this case and its relevance to the issue of informed consent have been discussed in 1.2.1. Discussion here will be confined to causation.

[97] Other cases to be considered here include: *Lenis v DeVilliers* 1992 Ont. CJ LEXIS 332, *Kitchen v McMullin* (1989) 62 DLR (4th) 481, *Haughain v Paine* ((1987) 27 DLR (4th) 624, *Zubrug v Bowie et al* (1992/93) 91 DLR (4th) 599, *London Loan and Savings Co. of Canada v Brickenden* [1934] 2 WWR 545 (550-51 on Causation; which was adopted by *Arndt v Smith* [1996] 7 Med LR 109, 116. ii). Additionally, *Snell v Farrell* [1990] 2 SCR 311 on causation of injury (by chicken pox) which was also considered in *Arndt v Smith.* Notably, *Buchan v Ortho Pharmaceutical (Canada) Ltd* [1986] 25 DLR 4th 658 is opposed to an extent by *Arndt v Smith*, on the (*Reibl*) modified objective test for causation – but this is of marginal importance because *Buchan* was a products liability case rather than an informed consent case. On Drug risk warnings: *Davidson v Connaught Laboratories et al* (9180) CCLT. 251 (Ont. HCJ.), 276.

[98] (1981) 112 DLR (3d) 67.

[99] Ibid., 78. Cf. 3.3.

The value of this case lies in its discussion of materiality of risks[100] and causation because this case preceded *Reibl v Hughes* in which the doctrine of informed consent was accepted and then modified. Where there is a duty to warn of risks, as there was in Canada at the time, these risks are defined as those which 'would reasonably be expected to affect the patient's decision to submit or not to submit to a proposed operation or treatment.'[101]

Taking a step forward, *Reibl v Hughes* adopted and modified the American doctrine and, accordingly, modified the English test for causation to become more objective. While the test in some American jurisdictions is objective, the Supreme Court of Canada adopted a modified objective test to include some subjective elements[102] - possibly the legacy of English tort law. Chief Justice Laskin began with the American argument for an objective test for causation, noting that Canadian case law had hitherto employed a subjective test.[103] He said, 'An alternative to the subjective test is an objective one, that is, what would a reasonable person in the plaintiff's position have done if there had been a proper disclosure of attendant risks.'[104]

He recognised that a problem with the objective test lies in establishing causation where the reasonable patient would have acted contrary to the surgeon's recommendation. This would mean that the objective standard would 'put a premium on the surgeon's assessment of the relative need for the surgery and on supporting medical evidence of that need.'[105] He felt that it was for that reason that Brooke JA, who handed down the Appeal Court judgement, put forward a hybrid test.

Laskin CJC thought that the objective test did not leave the issue completely in the surgeon's hands because the patient's individual circumstance reduces the force of those recommendations. He argued that the better course was to balance the outcomes of having surgery and not having surgery, against one another. He felt that the objective test was the applicable one, but said that it should none the less be based on the decision a reasonable person *in the plaintiff's position* would have made. He said. 'In short, although account must be taken

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[100] In which it was held that, 'Materiality connotes an objective test, according to what would reasonably be regarded as influencing a patient's consent.' (1981) 112 DLR (3d) 67, 81.
[101] *Hopp v Lepp* (1986) 112 DLR (3d) 67, 80.
[102] Which has subsequently been adopted in Hawaii.
[103] 14-15.
[104] 15.
[105] Ibid.

of a patient's particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.'[106]

Buchan v Ortho Pharmaceutical[107] was not strictly a case of medical negligence or informed consent, but it did concern the medical arena and information to the patient and the court did discuss causation with reference to *Reibl v Hughes.*[108] The case concerned a woman who was insufficiently warned by the manufacturer that taking a particular contraceptive pill could lead to a stroke in some users. Although this case is complex,[109] it is only the arguments on causation which concern us here. The plaintiff established on balance of probabilities that the taking of the drug itself was the factual cause of the stroke suffered.[110] It was held that,

> 'While a low probability of injury or a small class of endangered users are factors to be taken into account in determining what is reasonable, these factors must be balanced against such considerations as the nature of the drug, the necessity for taking it, and the magnitude or the increased danger to the *individual* consumer.'[111]

Robins JA held that once it had been established that the defendant was in breach of its duty to warn prescribing physicians, there followed a reasonable presumption that the 'inadequacy of the warning was a contributing cause of the ingestion of the drug',[112] which was in turn a factual cause of the injury.

The plaintiff had to go on to prove that had she known of the risk, she would not have taken the pill because the final line of defence was that even if properly informed, the plaintiff would still have taken the contraceptive. The defence submitted that the trial judge ought to have applied the test as laid down in *Reibl v Hughes* rather than the subjective test beloved of the law of torts. The trial judge accepted the plaintiff's testimony that had she known of the risk she would not have used the pill, yet questioned the applicability of the objective test in products liability cases. He argued that the plaintiff would 'labour under a difficult evidentiary burden of adducing what a reasonable person in her particular circumstances would have

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[106] 17.
[107] *(Canada) Ltd* (1986) 25 DLR (4th) 658 (Ont. CA)
[108] Admittedly because the defence made it part of their case, but that is what makes it interesting here.
[109] It discussed product liability in tort generally, drawing on English, American and Canadian decisions. The case also considered the conduct of the prescribing doctor, the responsibility of the manufacturer and the discharge by the manufacturer of the obligation of information by adequately informing the prescribing doctor.
[110] 662-665 and 679.
[111] 678. Emphasis added.
[112] 682.

done',[113] if the test were to be strictly applied.

Accordingly the trial judge modified the *Reibl* test. Despite this, he considered the case in terms of the *Reibl* test (finding that 'a reasonable person in the plaintiff's position would not have taken the drug') as well as in terms of a more subjective test (finding that *this* plaintiff would not have taken the drug). Even though it was applied at first instance, Robins JA held that 'the *Reibl* test is inappropriate to products liability cases and ought not to be imported into this department of the law.' He went on to say, 'Needless to say, the *Reibl* test *must* be applied in Canada in *appropriate* medical malpractice actions.'[114] It seems that informed consent cases, while fitting broadly into the law of negligence, differ in Canada (and indeed in some American jurisdictions) in one important respect: the test for causation is a modified objective rather than a subjective one. It is difficult to see how this is not a policy-guided element of Canadian tort law.

Considering again the question encountered in English courts - of causation and the matter of a test for 'probability' or for 'possibility' - the court in *Rothwell v Raes*[115] decided the causation issue on possibility rather than probability, thereby recognising 'that causation may well have to be proved without resolving the conflicting expert evidence, but rather by adopting a "robust and pragmatic approach to the primary facts of the case."'[116] Here we see another apparent split from English courts. Yet English decisions from recent years[117] indicate that this split is not as dramatic as it seems at first glance because the courts *are* showing a tendency towards such a 'robust and pragmatic approach', as seen in *Lybert v Warrington Health Authority*.

The important issue of causation was highlighted in the recent informed consent case of *Arndt v Smith*.[118] There a new trial was ordered when the trial judge took purely subjective factors into account when determining causation. It demonstrates the ardour with which Canadian courts hold to the modified objective *Reibl* test. The case involved the failure of a

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[113] 25 DLR (4th) 658, 684 (the appeal), 46 OR (2d) 113, 147 and 8 DLR (4th) 373, 406.
[114] 685. Own emphasis.
[115] (1988) 54 DLR (4th) 193 (Ont. CJ).
[116] See comment by Puxon on *Bolitho v City & Hackney HA* [1993] 4 Med LR 392, 393. Cf. 4.3. & 6.2.
[117] For example *Smith v Tunbridge Wells*, *McAllister v Lewisham* and *Newell and Newell v Goldenberg*.
[118] [1995] 7 Med LR 108.

doctor to warn a pregnant mother of the risks[119] to her foetus from her own infection with chicken pox. Lambert JA held that there was no reason to alter the conclusions of the trial judge who had 'found that Dr Smith had failed to inform Ms Arndt of *all material* risks faced by Ms Arndt's foetus' which 'amounted to medical negligence.'[120] He went on to consider the nature of proof of a causal link between that negligence and the injury suffered by the parents through the costs of caring for a handicapped child.

Reibl v Hughes was correctly seen as authoritative on the matter. Lambert JA observed that 'usually the issue of causation is an issue of fact',[121] but that it had been altered by the modified objective approach taken by the court in *Reibl v Hughes*. Lambert JA summed up the matter succinctly when he said,

> 'The question has been changed. It is no longer whether the breach of duty caused the loss. Instead a new question has been substituted: Would the breach of duty have caused the loss if the plaintiff had been a reasonable person acting in his or her own best interests who was in the same objectively ascertainable circumstances as the plaintiff?'[122]

He called the test a 'substitute test' rather than a 'test about causation in fact' which 'removed from the trial judge the opportunity to assess the credibility of the plaintiff with respect to the state of mind of the plaintiff as it relates to causation ... and the opportunity to weigh the evidence of the plaintiff who may be credible but possibly mistaken on that point.'[123]

What is excluded is evidence on the plaintiff's state of mind and what is substituted is the reasonable patient as opposed to the reasonable practitioner (the *Bolam* test being inapplicable). What needs to be assessed by the court is 'behaviour which might reasonably be anticipated and foreseen: not in relation to anticipated reliance [of the patient on the practitioner in what Canadian courts see as a fiduciary relationship[124]; not in relation to causation in fact; but

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[119] 2.3% of a significant birth abnormality and 0.23% of a serious birth abnormality.
[120] 112. Emphasis added.
[121] 114.
[122] Ibid.
[123] Ibid. This is a similar situation as we have seen adopted in English courts in an *ad hoc* way and without the rationale of a coherent test to justify disregarding the plaintiff's testimony. Instead, English courts contend simply that it is the function of the court to determine the issue on the facts.
[124] On the fiduciary nature of the relationship between doctor and patient, consider *McInerney v MacDonald* [1992] 2 SCR 138; *Norberg v Wynrib* [1992] 2 SCR 226; *Goodman Estate v Geffen* [1991] 2 SCR 353 (at 370 on categories of influence of a doctor on a patient). On causation principles and their application in fiduciary relationships see *Kenny v Lockwood* [1932]1 DLR 507 and *Halushka v University of Saskatchewan* 53 DLR (2d) 436.

in relation to a *form of deemed causation in law.*'[125]

The court in *Arndt v Smith* accepted and adopted the *Reibl* test, but went on to define it further on the ground that the test does not cater for some situations. Lambert JA asked, 'What happens if some reasonable patients in the actual patient's position would have undergone the treatment and others would not?'[126] In the face of the risks of abnormality in the foetus, the relevant decision would have been whether or not to terminate the pregnancy. Interestingly, Lambert JA drew on *Buchan v Ortho Pharmaceutical* saying,

> 'So long as the court is satisfied that *the plaintiff herself* would not have used the drug if properly informed of the risks, this causation issue should be concluded in her favour regardless of what other women would have done.'[127]

Mr Justice Lambert concluded from this that the court distinguished the *Reibl* causation test where 'the plaintiff's own evidence is likely to be neither more nor less suspect than in a case of a relationship between a doctor and a patient.'[128] Here we see the modified objective test becoming slightly more subjective.

The approach to causation adopted by *Arndt v Smith* is that which was adopted by Lord Thankerton in *London Loan and Savings Co. of Canada v Brickenden.*[129] In *Arndt v Smith* Lambert JA said that this test would apply when the *Reibl* test failed to provide a clear answer. He said,

> 'If that clear and consistent answer is not reached, then the plaintiff who was a victim of the wrong and who was deprived of a choice about the patient's own bodily integrity should have judgement in his or her favour.'[130]

To support this conclusion he cited the fiduciary nature of the physician-patient

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[125] 115. Emphasis added.
[126] 115. Lambert JA noted that Madam Justice Southin had raised this problem in *Hollis v Birch* (1993) 16 CCLT (2d) 140 (BCCA), 177.
[127] 115. *Buchan v Ortho Pharmaceutical (Canada) Ltd*, 686-687 per Mr Justice Robins. Cf. Chapter 5 on Expert Evidence, the *acceptance* of such evidence by the court and judicial hegemony.
[128] Ibid.
[129] [1934] 2 WWR 545, 550-51. 'When a party, holding a fiduciary relationship, commits a breach of his duty by non-disclosure of material facts, which his constituent is entitled to know in connection with the transaction, he cannot be heard to maintain that disclosure would not have altered the decision to proceed with the transaction... . Once the Court has determined that the non-disclosed facts were material, speculation as to what course the constituent, on disclosure, would have taken is not relevant.'
[130] 116.

relationship,[131] the duty of communication on the part of the doctor[132] and the effect on the patient's life of the wrong suffered. Most importantly, the court argued that with possibilities so split, to reach a conclusion about the plaintiff, based on possible or probable percentages, 'is not an analysis of causation at all, nor an analysis of a framework for legal responsibility, but ... pure speculation.'[133] He held that the relevant risks would have persuaded a 'significant number of reasonable and prudent prospective mothers in the particular objectively ascertainable circumstances of Ms Arndt, acting rationally in assessing the risk ... to undergo an abortion and try again.'[134]

In summary, the test for causation in Canada remains that set out in *Reibl v Hughes*, but with the addition created by *Arndt v Smith*. The test is what is now known as the modified objective approach which considers the probable decision of the reasonable patient in the same objectively ascertainable situation as the plaintiff. If the result of this inquiry is split, judgement should be given in the plaintiff's favour in view of the fiduciary nature of the doctor-patient relationship.

4.6. AUSTRALIA

Australian decisions have arrived at a different test from those adopted in either England or Canada in as much as the High Court adopted the doctrine of informed consent in *Rogers v Whitaker*,[135] and rejected the conclusiveness of the *Bolam* test.[136] At the same time Australian law maintains a subjective test for causation. It can be seen as a combination of different elements of the tests in the other two systems in a way which makes it the jurisdiction most sensitive to the particular patient.

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[131] Lambert JA said at 116, '[The relationship has the characteristics of] reliance, vulnerability, and trust, on the part of the patient, and skill, responsibility, and power, on the part of the Doctor.'
[132] Here citing *Hopp v Lepp*, *Kenny v Lockwood* and *Halushka v University of Saskatchewan*.
[133] 117, here citing *London Loan and Savings Co. of Canada v Brickenden*.
[134] Ibid.
[135] [1993] 4 Med LR 79, [1992] ALJR 47.
[136] Other cases include the following: on loss of opportunity and causation: *Battersby v Trottman* (1985) 37 SASR 542, *E v Australian Red Cross* (1991) 27 FCR 310, *Daniels v Burfield* 1991 AUST SASC LEXIS 1769, *Albrington v Royal Prince Alfred Hospital* [1980] NSWLR 542, *O'Shea v Sullivan & Another*, (per Smart J), unreported, May 6 1994 and *Arrowsmith v Haines*, Court of Appeal, unreported, August 21, 1990 (per Kirby J at 14); on the practice of careful and prudent doctors (i.e. *Bolam*) as the sole test (also from *Hart v Chappel*): *Petrunic and Another v Barnes* (1988), Australian Torts Reports, Case No. 80-147, page 67,321. For a summary of the general law of medical liability in New South Wales, see *Crisp v King*, per Wood J,

Prior to *Sidaway*, a full court had in *F v R*[137] already moved away from the *Bolam* test, while still approaching the matter on the basis of the doctor's duty of care. Some years later, the case of *Ellis v Wallsend District Hospital*[138] emerged as important in demonstrating a judicial ability to draw inferences within the subjective test. Samuels JA felt he was able to consider the matter '... from her evidence as a whole, taking advantage of the light which that cast upon her character and likely attitudes.'[139] Unusually, *Ellis* tackled causation before considering negligence because that was the sequence of grounds on which the judgement was being appealed.[140] Despite the fact that no negligence was found, and following a discussion of vicarious liability, causation was given full treatment.

Delivering the judgement of the New South Wales Court of Appeal, Kirby J held that 'Cole J was correct in applying the "subjective" test rather than an "objective" one on the question whether Mrs Ellis would have undergone the operation had she been fully informed ...'. He went on to say, 'It is not whether a hypothetical "reasonable" patient or even the "reasonable patient in the position of the plaintiff" would have accepted or rejected the treatment ...'.[141]

This is clearly opposed to the position in Canada and is possibly a matter of the luck of the draw (of judges).[142] Samuels JA stressed that the trial judge erred in 'taking the view that the appellant's failure to offer any evidence as to how she would have reacted to information ... put her out of court on the issue.'[143] He considered that, '[t]he absence of direct evidence as to how she thought she would have behaved at the time did not preclude consideration of the issue on a subjective basis.'[144] This indicates that while the subjective test for legal causation is the appropriate one in Australia, the court remains free to determine the issue regardless of direct

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unreported, December 2, 1992, No. 15405 of 1991, 84-91 and *Dunning v Scheibner*, unreported, Feb. 15, 1994, No. 13776 of 1988, 61 *et seq*.

[137] (1983) 33 SASR 189.

[138] [1990] 2 Med LR 103, (1989) 17 NSWLR 552 - which was applied in *Hart v Chappel* [1994] 5 Med LR 365, 376 in respect of causation.

[139] (1989) 17 NSWLR 552, 590A.

[140] As mentioned elsewhere, this is the sequence in which the patient thinks the issue through and in which the plaintiff presents argument; though it is not the usual sequence of a judgement.

[141] 108.

[142] See Kirby, M. 'Informed Consent: What Does it Mean?' (1983) 9 *Journal of Medical Ethics*.

[143] 123.

[144] Ibid.

evidence from the plaintiff.[145]

Until *Rogers v Whitaker* in 1992, Australia had been hanging on to *Bolam*'s coat tails with regard to informed consent. In *Rogers v Whitaker*, however, the court drew on American and Canadian authorities to adopt the doctrine.[146] The causation inquiry is more significant once a jurisdiction adopts informed consent. With respect to Australia, the interest lies precisely in the fact that there was no reformulation of the existing subjective test for legal causation.

In *Rogers v Whitaker*, the test for causation was held to be subjective on the basis of the law of torts. Mason CJ found that there was no need to deal with causation in the appeal because the trial judge had already found that 'the respondent would not have undergone the surgery had she been advised of the risk ...'; the appellant did not appeal that finding.[147] Yet there is some evidence to indicate that some form of objectivity, albeit in terms of materiality, is still applicable. Mason CJ had held that 'the risk was material in the sense that the reasonable person in the plaintiff's position would be likely to attach significance to the risk and thus required a warning.'[148] Thus the test for materiality was used in conjunction with the causation inquiry.

The causation inquiry remained wedded to its subjective positioning in the law of torts in the New South Wales Supreme Court decision in *Hart v Chappel*.[149] In this case the plaintiff claimed for alleged failure to warn of the chance that there would be damage to the laryngeal nerve during throat surgery. Donovan AJ was able to hold the omission to be negligent, having held that a reasonable person in the plaintiff's position would have attached significance to such a warning and that, in accordance with the materiality test set out in *Rogers v Whitaker*, the reasonable medical practitioner should have been aware of this.

He was then obliged to move on to the issue of causation, with which he was able to dispense remarkably quickly. Adhering to the subjective test, the judge held that the question

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[145] This situation was encountered by the English court in *McAllister v Lewisham* discussed in 4.3. above.
[146] While at the same time finding the term 'informed consent' anathema.
[147] 84.
[148] Ibid. Cf. 3.3.
[149] [1994] 5 Med LR 365.

was 'whether *this* patient would have had the operation had a warning been given.'[150] However, in the same way as the Canadian court did in *Arndt v Smith*,[151] the Australian court advanced its test to take into account situations not covered by the test laid down in *Rogers v Whitaker*. Donovan AJ said,

> 'The question goes further than that because in her case it is not so much a question of whether she would have had the operation *at all* if a warning had been given but rather whether she would have had the operation *at this time* and *at the hands of Dr Chappel*.'[152]

The argument here is already framed in a subjective context. It is for this reason that Sidaway *cannot* apply. Here the test can be seen to be becoming *even more* subjective, or at least allowing an existing subjective test greater flexibility at the hands of the plaintiff. Mr Justice Donovan held that while the operation would have been necessary at some time, she need not have had it at that particular time. He considered that he was not bound by the defense testimony to the contrary.

Drawing on *Ellis v Wallsend District Hospital*, he said that 'in coming to a conclusion about what the plaintiff would have done, the test which [he] must apply is the subjective test ...'; but he contended that he was entitled to draw certain inferences of legal causation.[153] He said that the plaintiff appeared to him to be a cautious person who was meticulous about her health. He also took into account evidence given by medical professional witnesses who knew the plaintiff at the material time and concluded that 'the important thing was the consequences which might happen to her rather than the statistical likelihood of risk.'[154] He found that she would have deferred the surgery given the warning of risk.

This decision was upheld in the appeal to the High Court of Australia.[155] Significant to the present chapter, one of the grounds of appeal was that of causation. That ground had two facets to it. The first facet argued that causation did not need to be established because the issue

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[150] 375. Emphasis added.
[151] *Arndt v Smith* 1995 [7] Med LR 108. Cf. 4.5. and consider, in this context, what is to be argued in 6.2.2. on the loss of the chance to engage an alternative surgeon.
[152] 375. Emphasis in original. Consider, in this light, the matter of information on the physician and how that could affect the matter of informed consent. This will be discussed in 6.2.
[153] 376. As did the English court: consider the discussion of *Lybert v Warrington Health Authority* (Cf. 4.3. above).
[154] Ibid.
[155] *Chappel v Hart* [1998] HCA 55.

was in fact one of 'the loss of a chance to have surgery performed by somebody else at some other time'[156] and hence that the issue was not one of physical injury. On causation, Gaudron J considered that the court would have to be satisfied by evidence as to what Mrs Hart would have done in the presence of a warning. He went on to dismiss the loss of chance argument in the following way:

> 'If that evidence is to the effect that the injured person would have acted to avoid or minimise the risk of injury, it is to apply sophistry rather than common sense to say that, although the risk of physical injury which came about called the duty of care into existence, breach of that duty did not cause or contribute to that injury, but simply resulted in the loss of an opportunity to pursue a different course of action.'[157]

The second argument of the appellant in respect of causation had two aspects to it. The first was that because the surgery was medically inevitable and because the risk was inherent in the surgery, Mrs Hart did not suffer any legal damage. The second aspect was that Mrs Hart suffered a random risk of infection, but that she voluntarily undertook the risk. Again, Gaudron J dismissed these arguments because it (the argument) assumed that the degree of risk would remain the same regardless of the experience of the surgeon. Additionally, the argument assumed that the damage suffered was simply the exposure to risk; this assumption, he held, was fundamentally flawed. On voluntariness, Gaudron J had the following to say:

> 'The second aspect of the argument must be rejected because it treats the infection which occurred as a supervening event breaking the chain of causation which would otherwise begin with Dr Chappel's failure to inform Mrs Hart of the possible consequences in the event of perforation and subsequent infection. It is contrary to common sense to treat part of the very risk which called the duty into existence as a supervening event breaking the chain of causation beginning with the breach of that duty.'[158]

By this point the test bears a remarkable similarity to that in England, with the vital difference in the law between the two systems being that in Australia the doctrine of informed consent has been adopted as describing the standard of care, while in England it has not. It is the combination of the adoption of the doctrine and the maintenance of the subjective test that makes Australia the most radical and patient centric of the jurisdictions under discussion, with South Africa not far behind.

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[156] Per Gaudron J.

[157] An exact page reference for this quote is unavailable because the judgement is unreported but is available on the internet.

[158] See note 157 above.

4.7. SOUTH AFRICA

The first item which must be established in the plaintiff's mind in negligence cases, is that of factual causation.[159] In *Blyth v van den Heever*[160] Corbett JA, having considered the expert evidence in the field, held that the probabilities lay in the appellant's favour and went on to consider whether that 'eventual result can be attributed to negligence on respondents' part.'[161] Here we see that the inquiry into factual causation preceded that into negligence. This differs in informed consent cases only in that having found for the plaintiff on factual causation and negligence, the court may then consider legal causation in terms of a *conditio sine qua non.*

Richter and Another v Estate Hammann[162] concerned negligent treatment as well as failure to warn of dangers inherent in the surgical procedure.[163] The hindsight of the plaintiff is of note in this case.[164] The plaintiff alleged that had she been warned she would not have consented; yet because the defendant was deceased and his notes were inconclusive on the matter, the court was entirely dependent on her evidence. Having held that *if* (which was not proven) Dr Hammann had not mentioned these risks, he would not have been negligent in that omission, Watermeyer J went on to note,

> 'Plaintiff would of course have had the further problem of having to show that her disabilities were caused by the failure to warn, and this would have entailed proof at least of the fact that if Dr. Hammann had told her that the incidence of risk was as low as that set out above she would still have refused the operation.'[165]

He said that he could not attach much weight to her evidence on this matter in view of the fact that it was clouded by hindsight.

In a case similar on the matter of causation, the court in *Friedman v Glicksman*[166] found that the doctor had a duty to inform a pregnant woman of birth defects to her child following her questioning him on the matter. The birth of the disabled child would have been caused by the

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[159] In order to determine against whom the action might lie.
[160] 1980 (1) SA 191 (AD), 203C-D, 208A and 212A where Corbett JA summed up the question for the court: 'On appeal, therefore, this is really the crux of the matter. Does the evidence in regard to the clinical history so rebut the theory advanced by appellant's experts [that the sepsis complained of was caused by alleged medical mismanagement] as to non-suit the appellant?'
[161] 220B.
[162] 1976 (3) SA 226.
[163] Discussion in the present thesis is confined to the latter claim.
[164] 230B-C, and 230G-H.
[165] 233D.

negligent omission of the doctor to inform the plaintiff, only if she would have terminated her pregnancy had she been so informed. Evidence of what choice the plaintiff would have made is established by the law of contract through the exchange between doctor and patient.

As we have now seen, until *Castell v De Greef*,[167] South Africa had adhered to a *Bolam* style standard on the matter of information. This situation changed with the appeal of *Castell v De Greef* where the Cape Provincial Division of the Supreme Court held that the standard on consent set by *Rogers v Whitake*r was the appropriate one. The court held that (with the exception of therapeutic privilege and subject to an assessment of the materiality of the risk),

> 'The formulation laid down in Australia in *Rogers v Whitaker*, being in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving, as well as with developments in common law countries and judicial views in continental Europe, ought to be adopted here, suitably adapted to the needs of South African Jurisprudence.'[168]

Unlike other Commonwealth jurisdictions, the court held that the defence of *volenti non fit iniuria* was available.[169] The use of the *volenti* defence is anomalous in the context of informed consent because of the relation of the defence to contributory negligence and, more importantly, because being *volens* depends on both knowledge of the risk involved as well as the acceptance thereof.[170]

This turns almost the whole of the issue into a question of fact. Ackerman J had said of the *volenti* defence in *Castell v DeGreef* that the same issues of policy are involved as those which occupied the court in *Rogers v Whitaker* and that to test whether a patient was *volens* the quality of information given had to be assessed according to certain criteria. If the attack of the plaintiff is, 'I did not consent', the defence is, 'Yes you did, you were *volens*.' In assessing whether a patient was or was not *volens*, the court interrogates the adequacy and materiality of the information given and required.

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[166] 1996 (1) SA 1134.
[167] 1994 (4) SA 408.
[168] *Castell v DeGreef* 1994 (4) SA 408, 426D.
[169] 420 H-I and 425G-I. Cf. 3.2.2.3. & 3.3.3.
[170] Consider, in this context, judicial remarks in English courts; particularly those of Fox LJ in *Morris v Murray* [1991] 2 QB 6 (in the context of accepting a ride in a light aircraft knowing that the pilot had been drinking alcohol): '... the *volenti* doctrine can apply to negligence, though it must depend upon the extent of the risk, the passenger's knowledge of it and what can be inferred as to his acceptance of it.' Quoted in Markesinis & Deacon. 658.

Considering that in the majority of informed consent cases this knowledge of risks is precisely what is in dispute, it would appear a doubly anomalous defence to permit. Be that as it may, its use had placed the disclosure and materiality of risk in a contractual context and shifted the burden of proof onto the defendant.[171] *Volenti* is a subjective inquiry into whether an 'inference arises from all the evidence that plaintiff must have understood and accepted such a risk.'[172] This involves 'a subjective test of foresight which, once established, is deemed objectively to amount to causation.'[173]

The question at large is what has this to do with causation? The answer is that it had very little to do with causation. The judgement had already been through the scope of duty of care owed and established that the plaintiff voluntarily assumed those risks in undergoing surgery. But like legal causation has little to do with conventional understanding of cause and effect, so the operation of the *volenti* defence is still considered under the causation head, yet remains outwith any conventional semantic understanding of voluntariness. *Volenti* is established inferentially and proves causation the way *res ipsa loquitur* proves negligence, such that the mere act of participating in surgery is deemed to be causative. This is the same as alleging that with certain information, the plaintiff would not have 'volunteered' for the treatment.

When the question of causation is confronted, the matter still involves a conflict of fact. What it does not involve is a policy-guided inquiry into legal causation because factual and legal causation are subsumed in this aspect of the law of delict.[174] Rather, policy will have been considered at the level of the inquiry into whether or not there was a duty of disclosure on the surgeon. On that standard the plaintiff averred that, on the basis of not having been made aware of the chance of post-operative sepsis, she had not given her informed consent to the cosmetic surgery on her breasts.

It is noteworthy that under *volenti*, it is unnecessary to establish that connection because

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[171] See Boberg PQR. *The Law of Delict*. 1984. Juta. Johannesburg. 767-8. On the contractual context of the relationship between doctor and patient in England, as seen in terms of *The Social Contract*, see *British Medical Journal editorial* 1998; 316:1622-1623 (30 May), 'Renegotiating medicine's contract with patients'.
[172] *Rosseau v Viljoen* 1970 (3) SA 413 (C), 418A-C.
[173] See Boberg PQR (1974) 91 *SALJ* 19, 29 *et seq*.

it is established by inference. However, Ackerman J did suggest[175] that the causal connection should be in the sense mentioned in *Blyth v van den Heever.*[176] This seems an anomalous statement of the court, considering that in the context of *volenti* they were not going to get on to causation. What it does suggest is that there would be a test for causation built into informed consent cases were South Africa, like England, to scrap the *volenti* defence. More importantly, it supports the argument that *volenti* was used here as a legal test for consent and as a legal peg on which to hang disclosure cases.

Using the *volenti* defence as a test of fact and combining that test with a test for materiality taken from the Australian case law, the court was able, through this combination, to reformulate the South African law on informed consent to become as patient-centric as that in Australia. It is the patient-centric test taken from *Rogers v Whitaker* that told the court which information is material. After that, the *volenti* defence allowed the court to test whether the defendant had been aware of that particular piece of information. After that, which is the issue of wrongfulness, the court will ask whether any lack of awareness would have made any difference.

In this case, Ackerman J found that, 'in the circumstances Scott J was fully warranted in his finding that the plaintiff was aware of the risks involved ...'.[177] The plaintiff, however, had tried to persuade the court that she had been labouring under a misapprehension in respect of the consultation between herself and the surgeon. The court, therefore, found that as a question of fact, she was aware of the risks. The court drew certain conclusions to her detriment, from the fact that her husband, who was present at the consultation, was not called to give evidence on her behalf. Her evidence, therefore, lacked credibility. The court then went on to consider what the position would have been had she been aware of the risks.

On causation, the court used the same test as in *Blyth v van den Heever* and found that she would still not have refused the surgery or had an alternative procedure performed. This is because the rationale for having had the surgery was to avoid breast cancer - which other members of her family had contracted. Weighed against the risk of necrosis, the court found

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[174] See *Santam Insurance Company v Vorster* 1973 (4) SA 764 (A).
[175] 440J.
[176] 1980 (1) SA 191 (A), 208A and 223C-G.
[177] *Castell v DeGreef* 1994 (4) SA 408, 429.

that she would not have refused the surgery offered had she known of the risk. This demonstrates an injection of objectivity and an exclusion of hindsight similar to that employed by Canadian courts, which was also employed by Scott J in the court *a quo*. Of additional interest here is that even although the court used a patient-centric test, the plaintiff failed to win her case, which is perhaps a testament to the fairness of adjudication.

To return briefly to *Blyth v van den Heever*, Corbett JA had set out a *Bolam* style test in a therapeutic context.[178] Causation warranted a separate head in the judgement. The court held that it was to 'make its findings upon a preponderance of probability' in which the plaintiff bears the burden of proof[179] - that is determine whether it was more probable than not that the defendant's negligence was the legal cause of the injury suffered.

The decision in *Blyth v van den Heever* indicates that, although it was not necessary to discuss or argue the matter in *Castell v De Greef* in the context of informed consent, the test for legal causation in South African law is the same as that in English and Australian law. In the context of informed consent, the test would be a subjective one in which the plaintiff would have to prove that had he been aware of the risks which eventuated, he would not have contracted[180] to undergo that medical procedure at that time.

Although this is broadly in accordance with the South African law of delict, a different set of delict principles on voluntary assumption of risk is used in the operation of *volenti non fit iniuria*. Because delict principles are generally differently applicable in South Africa and because Ackerman J in *Castell v De Greef* cited with approval academic writings and case law in favour of a more objective test suitably modified to take into account subjective elements,[181] South African law will be guided by a combination of Canadian and Australian authorities - probably siding more with Australia if one gives weight to the fact that Ackerman J cited almost verbatim the test for materiality used in *Rogers v Whitaker.*

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[178] 220-21. Cf. 3.2.2.3.
[179] 208A-B.
[180] Note that the court in *Castell v De Greef* (409D and 425C-E.) considered that in issues of consent, 'in the South African context, the doctor's duty to disclose material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its *sequelae*.'
[181] 421E-I in which Ackerman J cited Giesen D *International Medical Malpractice Law* (1989) in which Giesen approved of the Canadian approach at 289.

4.8. CONCLUSION

The test for materiality dovetails with that for causation. This is important in the light of the argument in the preceding chapter that the inquiry into materiality and standard of care is the most important facet of the judgement from a policy point of view. The fact that it is connected with the inquiry into causation lends greater importance to the latter inquiry.

Several points are clarified by this discussion. The first is that the court's primary inquiry occurs at the level of liability and concerns the test for the standard of care and the matter of its breach. The matter of factual causation is then determined on the evidence and according to the *sine qua non* test, which is based on the test for materiality. Those inquiries settled, the issue of causation takes on a different nature in different jurisdictions according to the *result* of those inquiries. As Robins JA held in *Buchan v Ortho Pharmaceutical*,

> 'It can now be taken as a legal truism that the duty of reasonable care which lies at the foundation of the law of negligence commonly comprehends a duty to warn of danger; the breach of which will, when it is the cause of injury, give rise to liability... . Once a duty to warn is recognised, it is manifest that the warning must be adequate.' [182]

The adequacy of the warning is the subject of the present discussion. It has been found that different jurisdictions test that adequacy in different ways and on the basis of different policy considerations. This goes beyond the test for materiality and the argument that if the risk in question is found to be material, then it must be disclosed. Different tests for legal causation are employed, giving plaintiffs and defendants different respective advantages. In this way a judicial system can be said to be patient- or physician-centric to varying degrees.

Aside from the *Bolitho* case in England, which mixed the *Bolam* test with the causation inquiry, English courts find against the adoption of informed consent and in favour of settling the issue according to the *Bolam* test. After that and having classified such cases as falling within the ambit of tort law and negligence, a subjective test for causation is used.

Canadian courts, on the other hand, reject the *Bolam* test (although still find it useful as a matter of evidence), adopt and adapt the doctrine of informed consent and then consider the issue of causation in more objective terms than do English courts. In this way the approach of

Canadian courts is similar to that of some American jurisdictions. An advantage of this is that it is less likely to favour either plaintiff or defendant unduly and will tend to exclude hindsight.

Australian and South African courts adopt a third position. Like Canada, they accept the policy and ideology behind the doctrine of informed consent and reject the *Bolam* test. From there the two jurisdictions split. Australian courts, like English courts, see the issue as one of negligence and so adopt a subjective test for legal causation. South African courts see the issue as one of consent rather than negligence[183] and consider the matter on the facts and in a contractual context. This makes Australia the most radical of the jurisdictions discussed here because the plaintiff's chance of a verdict in her favour is greater when a patient-centric doctrine as well as a plaintiff-centric test are adopted. South Africa, too, has this radical potential, but it is at this stage still potential because South Africa has not had the opportunity to take the test as far as Australia did in *Chappel v Hart* and because *volenti* is a strong defence.

It is clear from the law of torts (seeking to compensate the particular patient for their actual loss) and from the tests for materiality that a subjective test favours the plaintiff. That the doctrine of informed consent is itself patient-centric is obvious from the discussion of this topic in Chapters 2 and 3 and from the legal etymology of the term itself. This argument places the *Bolam* test in the position of a safeguard for England against liberalising the law in this area in favour of the patient and it places the modified objective test in the position of a safeguard against further liberalisation in Canada. Australia remains the most liberal jurisdiction covered by this thesis because the inquiry there has more subjectivity than in any other jurisdiction.

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[182] *(Canada) Ltd* (1986) 25 DLR (4th) 658, 666-667.
[183] See *Castell v De Greef* 1994 (4) SA 408, 425E-F.

CHAPTER 5

THE EXPERT IN DISCLOSURE CASES

> ' ... there is no pretext which has not been used in some country or other, as a reason for excluding whole classes of witnesses. Combine all these pretexts, and there would no longer be any admissible judicial evidence.'[1]

5.1. INTRODUCTION

The function of the expert is to assist the court by explaining medical matters which the court will then understand.[2] In the civil law cases under consideration, the expert is a medical practitioner who, in negligence matters, will comment on the acts (or omissions in disclosure cases) of one of his peers. In the context of the medical thought-collective discussed in 2.3., of which both defender and witness will form a part, it will become apparent that there are differences between legal, medical and lay thinking. It is the expert witness who is able to interpret the medical fact genre for the benefit of the court; he is a tool in the hands of judicial process in the adversarial system.[3]

Medical thinking and practice diverge: the theory describes the singular yet exemplary while the practice in each instance works with the plural yet unique.[4] This can be problematic when it comes to the testimony of an expert witness on desirable clinical actions. The expert was not at the consultation, yet he remains within the thought-collective. The result is that his testimony will be unable to take account of intuition in the doctor-patient encounter.[5] This gains enhanced importance in respect of the communication between doctor and patient which gives rise to the facts of a disclosure case.[6]

Once the expert is seen as an aid to the judicial process, we can consider him in the context of the inquiry into informed consent. In Britain, for example, we would need to see him as commenting on or as representing a responsible body of medical practice and as asserting that

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[1] Jeremy Bentham *Treatise on Judicial Evidence* 1825.
[2] Cf. 5.2.
[3] It is this expertise, attested to in the courts, which sets the doctor apart from the patient and, in the case of Canada, places the relationship in the context of fiduciary relationships generally.
[4] Cf. 2.3.
[5] Cf. 1.3.2.

he would or would not have made the omission that the actual defender in fact made. This is because of the tests set out in *Bolam* and in *Hunter v Hanley*.[7] The extent to which this evidence will dispose of the case in a particular jurisdiction has been discussed. In this chapter we will be considering how judiciaries have applied the rules of expert evidence to disclosure cases, as well as those points in the judicial inquiry at which medical evidence is more or less influential on the decision of the court.

In each jurisdiction, the court declares itself the arbiter on the matter. Indeed, in Britain a practice must be rightly adopted by the defender;[8] and in South Africa the court declared itself sovereign over expert evidence.[9] It is self-evident that this declaration is a policy issue: empowering itself to determine the value of evidence places the court in a very strong position from that point onwards, despite the evidence itself. Our interest lies in the use of expert evidence to answer those questions which speak to judicial tests in disclosure cases, which were discussed in Chapter 3.

Certain matters can be assessed by lay persons, but others require medical knowledge. Factual causation, for example, is a question of medical fact and requires medical evidence.[10] Legal causation, on the other hand, may or may not require medical evidence, depending on the form of testing used by the court, and on the credibility of the plaintiff's testimony on the matter. This has been discussed in the previous chapter. Here, that discussion is useful as a platform from which to consider the weight of particular evidence across various jurisdictions in the inquiry into legal causation and, more specifically, into materiality of information.

Because medical evidence determines causation questions and disclosure cases hinge on the causation inquiry, the importance of expert evidence cannot be underestimated and, therefore, the matter of materiality is crucial.[11] It must be remembered that we are dealing here with access to information and with omission liability generally. It is in the territory of omission liability that the importance of the expert comes to the fore more prominently because

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[6] This is a matter of communication, which has been highlighted throughout this thesis, specifically in 3.3.6.
[7] Cf. 1.3.3.
[8] Cf. 1.4. This is a position outlined by Lord Donaldson in *Sidaway* and which was suggested by the House of Lords' judgement in *Bolitho* (Cf.54.3.). It is also suggested in the judgement on *Smith v Tunbridge Wells HA*.
[9] Cf. 3.2.2.3.
[10] Cf. 3.2.1. and 4.1.

of the importance of hypothetical causation. Crucial to a determination of whether a piece of information is material, will be the test used by the court and, of course, the evidence of the expert on the matter. It is the expert, in conjunction with the evidence of the pursuer, who will fill in many of the missing pieces, whichever judicial test is employed. This is because whether or not information which is said to be material was actually given, will be a matter of assessing and interpreting the defender's clinical notes. This brings us full circle back to the matter of communication between doctor and patient.[12]

This chapter will consider those points in the judicial inquiry of each jurisdiction, at which expert evidence will be useful to the court to varying degrees.[13] The preceding chapters have outlined the doctrine of informed consent as accepted, rejected or adapted in separate jurisdictions. Common Law jurisdictions are not in agreement as to the use of the expert witness; there is a split between those adopting the doctrine and those rejecting it. This is evident in the weight given to expert testimony and the extent to which that testimony, taken as a whole, is decisive of the case before the court.

In cases of alleged medical negligence the plaintiff cannot know any fact concerning the alleged breach of duty until he or she has information that the surgeon did not act in accordance with the standard of care required of surgeons.[14] He or she can get this only information from other medical professionals.

This chapter will begin with the general principles within the law of delict or torts and the rules on the acceptance of expert evidence. Having considered the law of negligence on the expert in each jurisdiction, we will want to consider the case law in detail, in order to ascertain how these principles have actually been applied in disclosure cases. Now we can consider the consent scenario which we by now know so well: in the case of Canada in *Reibl*, Australia in *Rogers*, South Africa in *Castell*, Scotland in *Moyes* and England in *Sidaway* - though it will be

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[11] Cf. 3.3.

[12] Cf. 3.3.6. and Cf. comments on the inferences drawn by Scott J in *Castell v DeGreef* in 4.6. and 5.4.3.

[13] Especially in 5.4.

[14] In *Hadley v Allore* et al (1985) 53 OR (2d) 419, 423 McKinilay J of the Ontario High Court commented on 'informed consent' as analysed in *Reibl v Hughes*, saying that '[i]n such a case, the plaintiff could only know the "fact or facts upon which he alleges negligence", when he discovers that the results of the procedure

instructive to consider the preceding cases too, and in the case of England to consider the 'erosion' cases, because they are the ones which go on to consider causation and hence the cases in which the expert is more important in disclosure cases.

The split between Commonwealth and British jurisdictions can be placed in the category 'risk assessment'. It will be remembered from previous chapters that in **disclosure** consent cases, typically the plaintiff or pursuer has suffered some harm from the eventuating of a risk inherent in the medical procedure to which broad consent was given. That plaintiff would be asserting that had they known of that risk, they would not have had the treatment and would hence have remained unharmed.

5.2. THE MEDICAL PRACTITIONER

5.2.1. USED BY THE LAW

The law needs to enlighten itself on matters falling within other discourses – in this instance on medical matters. For this purpose, the expert medical witness acts as an interpreter: he is asked questions by counsel and by the court, answering them in order to allow the court to understand the facts of the case. The court interprets those facts in the context of a legal test, to arrive at a decision on liability or culpability.

Medical experts have been used by the law in this way for some centuries. In the seventeenth and eighteenth centuries, the testimony of medical practitioners was also used for certificates of competence, religious conformity and the good character of colleagues within the profession for the purpose of gaining ecclesiastical licences to practice.[15] In various capacities, and by the nature or their professional duties, practitioners often come into contact with legal machinery at some time in their career. In the present context, contact with the law is as defendant or as witness. The latter developed from the early use of medical experts in criminal matters. With the explosion of professionally trained medical practitioners in the nineteenth century came a corresponding increase in their use as witnesses in criminal trials because of the

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performed were different from what the surgeon had led him to believe and at that point could possibly assert misrepresentation.'

[15] David Harley 45-46.

growth of confidence in scientific evidence and reasoning.[16]

Of anecdotal interest in medico-legal terms is the use of midwives in the eighteenth century to extract, as a vocational obligation, a 'statement *in extremis*' from a woman in labour about the true identity of the father of the child for use in adultery cases and maintenance matters.[17] Such a statement took evidentiary precedence at a hearing. Medical professionals were also increasingly used in rape, abortion and infanticide trials from the beginning of the Industrial Revolution and the credibility of their evidence rested more and more on their own integrity. Even so, the professional witness remains an alien in the legal environment - a useful tool in the hegemonic process that determines culpability and liability through credibility.

We are now considering a facet of civil law. In negligence cases the personal and academic integrity of witnesses is important insofar as it speaks to credibility. During legal examination, cross-examination and re-examination, there is the perceived need to discredit witnesses.[18] In the context of the reasonable medical practitioner, a responsible body of medical opinion is not a matter of numbers, but of credibility. In *DeFreitas v O'Brien and Connolly*,[19] for example, it was held that there is now a recognised sub-speciality of spinal surgery which should be judged by its own standards. The question is one of the reliability of the witness called as well as the internal consistency of his evidence. But the question whether one specialist is enough is also raised. One witness would be sufficient if that one witness was both credible and representative of a responsible body of opinion.[20] It is questions of internal consistency and credibility that must be confronted when dealing with the expert witness.

5.2.2. THE EXPERT WITNESS

The Medical Witnesses Act 1836 was the first legal provision which allowed for the payment of

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[16] Another facet involved the issuing of medical certificates excusing witnesses, expert or otherwise; this was the beginning of an insanity defence to be elaborated in the nineteenth century.

[17] See P C Hoffer & N E H Hull *Murdering Mothers* 13-17.

[18] In *Maynard v West Midlands HA* [1985] 1 All ER 635 court overturned the earlier decision in which the court had made a preference for one body of reasonable opinion over another reasonable body of opinion.

[19] [1995] 6 Med LR 108.

[20] *Scott v Highland Health Board* (unreported, Outer House, 1981) concerned the allegedly negligent interpretation of a femur x-ray by a consultant radiologist. The Pursuers instructed 2 orthopaedic surgeons who believed the radiologist ought to have been able to interpret the x-rays correctly. The Defender called a

money to expert witnesses in an attempt to offset the pessimistic view that associated involvement in testimony with loss of income through time wasted. That act marked the coming out of a dark period of medico-legal scholarship after which, but not necessarily as a result of which, such work came to be seen as more respectable within the profession. But medical witnessing is not without its troubles.

An expert was not an independent witness in the post-medieval period, but a neighbour who gave an opinion on a medical condition in his official or bureaucratic capacity. The 'expert witness can be said to have fully emerged into the legal forum'[21] with a more organised medical profession in the eighteenth century. The development of the medical witness progressed alongside legal developments in the modern adversarial system. Yet partisanship remains, although in a different form: in a negligence action, victory is often a matter of which side has presented its testimony most convincingly.

The discourses of medicine and law, both of which lay claim to truths which serve different social functions, meet *inter alia* at the point of the legal employment of experts. The professional witness is used by the law to legitimate accounts of fact situations *vis-à-vis* medical matters. The question is: which situations justify the application of a particular legal rule and the appeal to expert analysis and opinion? For example, at the practical level 'insanity' is different for lawyers and for psychiatrists; this is why expert evidence is an important if problematic sphere of legal practice and is important in the 'epistemological game played out in the courts.'[22]

The question of credibility of expert witnesses is answered only through law's observation mechanisms which embrace some areas of science less readily[23] than others, particularly in view of the modern tendency to give a specific name to non-specific symptoms.[24] Child welfare, for example, is seen as less acceptable than the 'pure' sciences and thus the acceptance of the evidence of 'psy' professionals will be contentious, although on the increase,

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consultant radiologist who believed failure was not negligent. The court held that it was entitled to rely on evidence of the consultant radiologist as he was an expert in the same field as the defender.

[21] Gee & Mason 23.

[22] Nerhot 324.

[23] Such as the 'psy' disciplines.

[24] Consider, for example, the courts acceptance of Repetitive Strain Injury.

especially in child welfare cases.[25] The Royal Commission on Criminal Justice[26] has advised a Forensic Science Advisory Council which would have an 'accreditation requirement' according to which only accredited witnesses would be able to give opinion evidence. However, an expert will still have to prove his experience through his *curriculum vitae*.

With these methods, the law maintains primacy: information is legally viewed, while it remain operationally more specific to the disciplines concerned. In *Frenchay Healthcare NHS Trust v S*, the court held that '[t]he court [has] the ultimate power and duty to review the doctor's decision of what was in the patient's best interests ...'.[27] Then, within the trial itself, the use of the 'ultimate issue' rule[28] ensures that the expert is for the use of the law to ensure that the expert does not transgress the law of evidence.

Complexity of multiple witnesses in 'child care' cases is evident from *Re G*[29] and *Re M*[30] which are apparently 'commonplace under the Children Act 1989.'[31] The need for expert witnesses is becoming more specific[32] because of the way in which medicine is sub-dividing into specialities. A witness who is an expert in these non-traditional specialities is needed. What emerges is law's demand for the legally valid expert; an expert of the law's own construction which touches the legal system at a convenient, legally determined, point.[33] That way it is easier to observe after the court has indicated the area of expertise required; for example the strict and specific guidelines of Wall J on this subject in *Re G*.[34]

The adversarial proceedings which constitute a major point of contact between doctors and the law, produce a suspicion of the law among doctors, despite the fact that the law in the

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[25] These 'psy' disciplines are producing syndromes all the time - e.g. battered woman syndrome. Acceptance by the judiciary operates in parallel with acceptance of syndromes by the psychiatric fraternity through successive editions of the *Diagnostic and Statistical Manual of Mental Disorder*.

[26] On this point, consider Royal Commissions and their place in legislation as well as autopoietic closure, infra.

[27] [1994] 1 FLR 485; June [1994] Fam Law 320.

[28] That an expert can comment on anything which does not pre-empt the verdict, or the question of culpability in criminal cases or liability in civil cases.

[29] *(Minors)* [1994] Fam Law 229 in which the plaintiff's solicitors instructed six experts, thereby necessitating the issue of judicial guidelines; this indicates that law will determine the use of experts.

[30] (Minors)(Care: Conduct of Proceedings) [1994] Fam Law 234.

[31] 'Newsline', (1994) Family Law 238 & 309.

[32] So much so that a conference was held in March of 1994 by the British Juvenile and Family Courts Society.

[33] King 1991, 313 et seq.

[34] *(Minors)* [1994] Fam Law 229.

United Kingdom is more favourably oriented towards medical practitioners. This constitutes an impediment to the maintenance of good doctor-patient relations.[35] Teff pointed out that the law is the only discipline that uses bipolar trials to determine facts and so it is unsurprising that experts tend to feel that legal tests are less rigorous than scientific tests because of differing notions of causation and the fact that legal analysis of scientific data is compromised by social pressures,[36] as well as by policy.

Because the question of negligence is a mixed one of fact and law, the dual function of expert evidence is both didactic and, by extension, assisting.[37] However, as has already been argued, courts continually assert predominance.[38] Further incidentals apply to expert witnesses. For example, legal advisers modifying their reports[39] is a common complaint which begs the question of motive. Secondly, the legal code of conduct barring counsel discussion with witnesses does not apply to experts,[40] thus arguably bringing the two discourses in line with one another.[41]

The expert remains a pawn of the law in that the law determines how to use him, when to use him and when his evidence is admissible - and indeed what evidence will be drawn from him by counsel. The fact that there is a disjunction between the standard of care actually employed in the clinical environment and that advocated by texts on a particular topic and hence often advocated by expert witnesses sums up many of the issues discussed here.[42]

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[35] Teff 8-9.
[36] Teff 12.
[37] Jackson and Powell on Professional Negligence 6.41 - 6.45.
[38] See Chapters 1 and 3.
[39] *Whitehouse v Jordan* [1980] 1 All ER 650, 655 per Denning. On expert reports generally see *Jackson and Powell on Professional Negligence* 6.45.
[40] Code of Conduct of the Bar of England and Wales 607.1.
[41] *Whitehouse v Jordan* [1980] 1 All ER 650. Some consultation is proper for the expert to enlarge on certain aspects of his evidence.
[42] This disjuncture was highlighted in a study involving the time to administration of antibiotics in children with meningitis. The article which accompanies the results asks somewhat rhetorically if expert testimony concerning the 'standard of care' ought to describe 'standard medical care' usually given rather than an idealised standard of care. See William L. Meadow, et al 'Ought "Standard Care" Be the "Standard of Care"?' (1993) 147 *American Journal of Diseases of Children* 40-44.

5.3. MEDICAL EVIDENCE

5.3.1. THE LAW OF EVIDENCE AND RULES OF POLICY

Courts of a particular jurisdiction can apply only their own rules of evidence. However, because of the comparative nature of medical law generally and informed consent in particular, there is a flow of precedent within the common law world.[43] The jurisdictions covered by this thesis show a difference of opinion in respect of informed consent. While the broad nature of the law of evidence in each jurisdiction may be similar,[44] certain differences among jurisdictions are apparent in respect of the weight given to the evidence of experts. Looking as the expert witness *per se*, the courts adopt similar approaches to matters of credibility. Where they differ is in respect of matters of weight. This is because of the different tests which have been discussed in preceding chapters.

According to Goldrein, 'it is easy to confuse the caliber of witness with the caliber of opinion he professes to hold'. Courts have developed rules by which expert opinion is assessed: if the opinions of one group of physicians are clearly (*Wednesbury*) unreasonable, that is that such views would not be held by any reasonable body of doctors, they can be disregarded.[45]

Policy considerations come into play in the law of informed consent through rules of evidence because it is that which governs the *application* of the substantive law of torts or of delict. Evidence is not itself a coherent body of rules, but that is what gives judges the leeway to mould policy.[46] In respect of disclosure cases, these rules are taken from those applicable to

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[43] Cf. Introduction to this Thesis.

[44] The position in Canadian law is succinctly set out in C A Wright & A M Linden *Canadian Tort Law (6ed.)* Butterworths. Toronto. 1975. 181-190. This work was published before the decision in *Reibl v Hughes* and hence excludes the matter of informed consent. That, however, is what is being discussed in this chapter. The same is true in respect of the Australian law of evidence. On omission liability generally, see Francis Tindale & Peter Cane. *The Law of Torts in Australia.* Oxford University Press. Melbourne. 1985. 327-329. On consent to medical procedures, see 229-230 in which the author cites the cases of *Chatterton v Gerson* in England and *Murray v McMurchy* in Canada, thereby indicating the similarities among the jurisdictions. On the South African law of evidence in delict, see P Q R Boberg. *The Law of Delict.* Juta & Co. Johannesburg. 1984. On the liability of the medical profession, see 347-55, 747, 750-51. On proof of the element of consent in the voluntary assumption of risk, see 725-7, 738-40 & 764-69. It is understandable that such similarities should exist given what Comparative law has to say on legal families; Cf. Zweigertz & Kotz.

[45] Goldrein 1315 (September 10 1994). See *Associated Provincial Picture Houses Ltd v Wednesbury Corp.* [1948] 1 KB 223.

[46] CP Harvey QC said, 'I suppose there was never a more slapdash, disjointed and inconsistent body of rules than that which we call the Law of Evidence. Founded apparently on the presumption that all jurymen are deaf

negligence[47] *simpliciter* and are then modified to fit the 'informed consent scenario'.

The burden of proof of all elements of the tort of negligence rests with the plaintiff[48] and the standard of proof is on balance of probabilities.[49] The role of the expert is to assist court or jury in the weighing of the medical evidence before the court. The expert will also be able to give opinion evidence on compliance with an accepted practice. We will see in this chapter that in England and Scotland, compliance with this standard will dispose of the case in favour of the defendant,[50] but in Canada and Australia that will not necessarily be the case.[51]

It is important to bear in mind that a judge may not prefer one body of professional opinion over another equally respectable body of opinion; to do so would constitute an error in law.[52] In *Moyes v Lothian Health Board*[53] the defender failed to give the warning which it was his custom to give. However, a responsible body of professional opinion, as represented by expert witnesses, attested to the propriety of not giving such a warning. This lead to the ironic position that even although the defender departed from his usual practice, the presence of an alternative practice which represented a responsible body of medical opinion meant that he could not be found negligent.

That said, Lord Bridge said in *Sidaway* that the matter of breach is to be based primarily on expert medical opinion and that if there is a conflict among experts, the judge will have to resolve that conflict.[54] As Jones put it, 'the court may condemn even a universally followed practice as to risk disclosure as negligent on the basis that the hypothetical reasonable doctor

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to reason, that all witnesses are presumptively liars and that all documents are presumptively forgeries, it has been added to, subtracted from and tinkered with for two centuries until it has become less of a structure than a pile of builders' debris.'; quoted in Spencer & Flinn *The Evidence of Children* (2Ed.) 1992. Blackstone. p31.

[47] Cf. Chapter 1 in which the fact that the law on disclosure matters falls within the law of negligence, is discussed.

[48] This may be reversed in situations in which the maxim *res ipsa loquitur* is applicable. Cf. 1.4. on the burden of proof.

[49] See *inter alia* Michael J Powers & Nigel Harris. *Medical Negligence (2Ed.)* Butterworths. London. 1994. 1.63.

[50] Ibid. 1.64 et seq. See also Michael A. Jones. *Medical Negligence.* Sweet & Maxwell. London. 1996. 3-017 et seq.

[51] Cf. 6.4.

[52] Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634, per Lord Scarman at 639.

[53] [1990] 1 Med LR 463, 470.

[54] [1985] 1 All ER 643, 662-3.

would not have adopted it.'[55] This might be done on the basis of policy; it may be in the public interest to declare a particular omission negligent even although an expert representing a responsible body of medical practitioners cites that omission as reasonable.[56]

In Britain, there is a single standard in law for negligence, whether that allegation is based on treatment or on the omission to give information. Indeed, negligence cannot be found where responsible experts called by plaintiff and defendant each attest to different points of view on whether or not they would have given the warning alleged to form part of the duty of care. However, in Chapter 3 it became apparent that in other jurisdictions, a different standard will be applied in respect of treatment from that applied in respect of information.

Both expert and lay evidence are important to this thesis, though in Britain expert evidence outweighs lay evidence in respect of the test for the standard of care, while in Canada, Australia and to a certain extent South Africa, the opposite is the case. In respect of factual causation, medical evidence is of equal importance in all jurisdictions; similarly, lay evidence will take precedence in respect of legal causation.[57] For these reasons, there are rules on disclosure of medical evidence - rules that will ensure that all parties have access to the same information about which they will be arguing.[58]

In Chapter 3 we saw that the test for the standard of care in Canada in respect of disclosure cases is based on the expectations of the reasonable patient in the particular patient's

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[55] Michael A. Jones. Ibid. 3-022. Jones cited the unreported case of *Neilson v Basildon of Thurrock Health Authority* (1991, QBD) in which Garland J referred to Lord Bridge's speech and substituted his own judgement on the ground of public policy.

[56] This was the rationale in *Reibl v Hughes,* though it was couched in terms of forseeability, while it was in reality an issue of policy to declare what is forseeable and what is not.

[57] However, it is not unknown that lay evidence should be used to resolve a conflict in the medical evidence. Consider, for example, *Pickford v Imperial Chemical Industries plc* [1988] 2 All ER 462 (HL) in which the diagnosis of repetitive strain injury was disputed and the medical evidence was in conflict on the matter of factual causation. For that reason, lay evidence of the plaintiff's colleagues in the workplace, was used to establish the probable organic origin of the injury actually suffered. This was, of course, not a disclosure case, but that does not alter the point being made here. Cf. 5.4.

[58] See *Naylor v Preston Area Health Authority* and the modification of RSC Ord. 38 r. 37, which, according to Nelson-Jones and Burton (Rodney Nelson-Jones and Frank Burton *Medical Negligence Case Law.* Butterworths. London. 1995 at p. 211-212), 'arose out of the difficulties that were experienced in *Wilsher v Essex Area Health Authority*' in which there had been no exchange of experts' reports on liability prior to trial. This thesis does not propose to discuss the rules of disclosure or to compare the jurisdictions with one another concerned, as it is, with the common law theory of informed consent and the policy considerations within that area of law. Consider, however, Powers and Harris. Ibid. 9.81 et seq. and 11.82. On admissibility and cogency, see 19.24 - 19.30.

position. This means that expert evidence will be less important than the court's assessment of the plaintiff's needs. In *Anderson v Chasney*[59] the court held that accepted practice should not constitute a conclusive defence because that would lead to groups of professionals closing ranks for mutual protection. This is because there might be a difference between a standard practice and a safe practice.[60] As one might expect, the position is the same in Australia where the test for the standard of care is an objective one. A cynical justification was given by King CJ in *F v R*:

> 'Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession. The court has an obligation to scrutinise professional practices to ensure that they accord with the standard of reasonableness imposed by law.'[61]

This was upheld in *Rogers v Whitaker.*[62] There have also been cases in England in which a standard practice has been held to be negligent.[63] This is because of the rationale outlined by Lord Bridge in *Sidaway* and noted above and because it would be disadvantageous to advances in science to hold all departures from accepted practice to be negligent.[64] The converse is also the case: an accepted practice might be held to be negligent.

In all jurisdictions covered it is the role of the court to use expert evidence to satisfy their own tests one way or the other - 'to provide evidence upon which the court decides whether there has been negligence or not.'[65] This evidence will be an assistance to the court. The weight which the court gives to the evidence will depend on the internal consistency of the evidence, whether it is corroborated by other witnesses and on the particular test formulated by the court to determine whether the standard of care has been complied with.

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[59] [1949] 4 DLR 71, 85, cited in Jones. Ibid. 3-025.
[60] Cf. *Crits v Sylvester* (1956) 5 DLR (2d) 601.
[61] (1982) 33 SASR 189, 194. Quoted in Jones. Ibid. 3-026.
[62] Ibid.
[63] In *Hucks v Cole* [1993] 4 Med LR 393, the court held that any lacuna in medical practice ought to be examined by the court. In addition, consider the arguments advanced in respect of the 'erosion' cases and the *Bolitho* judgement in 6.3.2.
[64] This is a point made in *Hunter v Hanley*1955 SC 200, 206 in which Lord President Clyde felt that the use of new techniques would be inhibited if all departures from accepted medical practice were considered to be negligent.
[65] Michael A. Jones. Ibid. 3.126.

5.3.2. RELEVANCE, WEIGHT, CREDIBILITY AND PLAUSIBILITY

It is fundamental that the evidence given is relevant to the case and that the expert speaks to the issues at hand. In civil procedures, the judge will ensure that any questions put to the experts are relevant to the *facta probanda* of the case. All negligence cases have to do with adequacy of skill; in disclosure cases this skill lies in the adequacy of the provision of information. Relevant evidence will contain factual information on the standards of the profession and opinion evidence on whether or not the defendant complied with those standards. This evidence is then used to flesh out the test for liability; in the case of British jurisdictions, if the conduct of the defendant complied with that standard, the defendant will not be held liable. On the other hand, failure to meet the standards of the profession will be assessed relative to the risk, to potential patients,[66] of holding a defendant not liable. This is clearly a policy area in which expert evidence has a crucial role to play.

It is also necessary that the evidence given, if it is not to be discounted by the court, is credible and plausible. In *Sidaway*, Lord Diplock said that the evidence should be evaluated in terms of a responsible body of opinion.[67] Other than where the evidence speaks to matters of medical fact or scientific technicality, the court may reject evidence on the grounds of credibility or plausibility. This would occur, for example, where there is a conflict internal to the evidence of one expert, where that evidence is contradicted by another expert or where it is internally inconsistent.[68] Much of this has to do with the demeanour of the expert in the witness box and, hence, the judge's views on the expert.[69]

Of importance to the present chapter is that a judge may accept or reject evidence on the basis of plausibility. This is important in a jurisdiction like England in which the case will turn on the inferences the judge is able to draw from the evidence of the medical expert. Whatever the jurisdiction, disclosure cases turn on whether a particular piece of information was in fact

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[66] See David Howarth *Textbook on Tort*. Butterworths. London. 1997. 77.

[67] [1985] 1 All ER 643, 659.

[68] On this point, see the analysis of *McAllister v Lewisham* in 5.4.4.1. below.

[69] Jones (Ibid. 3-129) cites the case of *Joyce v Yeomans* [1936] 1 All ER 540, 542 in which Brandon LJ said, 'Sometimes expert witnesses display signs of partisanship in a witness box or a pack of objectivity. This may or may not be obvious from the transcript, yet it may be quite plain to the trial judge. Sometimes an expert may refuse to make what a more wise witness would make, namely, proper concessions to the viewpoint of the other side. Here again this may or may not be apparent from the transcript.'

disclosed. This will often depend on the recollections of defendant and plaintiff and, consequently, on their credibility in the witness box. If a defendant does not have an exact memory of the consultation, the court may find that his evidence is not credible. If he is able to rely only on a recollection of his usual practice in such circumstances, that usual practice will have to be corroborated by an expert - probably a colleague. While corroboration is not necessary in civil cases, it will add weight to the evidence given.[70]

We are dealing here with evidence of an omission to take precautions which a reasonable medical practitioner would have taken - the omission to provide information on inherent risks and alternatives to the medical procedure proposed. Evidence will be led as to whether there was a usual practice, what that practice comprised and whether the defender complied with that practice.[71] The first two questions can be answered with the evidence of experts in the same field, but the third will require the evidence of the defender and the clinical notes taken at the time.

5.3.3. LAW AND MEDICINE: A MUTUAL PROTECTION SOCIETY?

We considered 'medical thinking' in Chapter 1 and can now see how medical and scientific thinking[72] differ from legal thinking. The difference is one between the bipolar based on proof on balance of probabilities or beyond reasonable doubt, in the case of adversarial law, and the multi-polar based on empirical proof in the case of medicine. In the sciences, the logic of a dispute is inductive and derived from observation whereas in law this logic is deductive and based on reasoning. In law it is often more a matter of form than content.

The content is supplied by the expert and manipulated in form by the legal practitioner.

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[70] In Scotland, for example, there is no requirement of corroboration in civil cases. After the abolition of this requirement judges' view of witnesses reliability and credibility took on a new importance, with greater reliance on their own 'instincts' about witnesses rather than on more demonstrable qualities of the evidence. (See, in this context, *Newell and Newell v Goldenberg* .) In law this should not really be the case. However, the case of *Morrison v J. Kelly and Sons* 1970 SC 65 makes it clear that the abolition of corroboration does not relieve a judge of her responsibility to arrive at a reasoned view of the evidence which can be justified to an appeal court. This can be compared with Lord Stott in *McLaren v Caldwell's Paper Mill* 1973 SLT 158. Interestingly, it used to be thought that expert evidence did not require corroboration anyway (see *Davie v Magistrates of Edinburgh* 1953 SC 34) but it seems generally accepted now that in criminal cases if the expert is speaking to one of the facts in issue, then corroboration is required. See also David M. Walker. *The Law of Delict in Scotland* (2Ed.) W Green & Son. Edinburgh. 1981. 385-386.

[71] These being the three questions set out by Lord President Clyde in *Hunter v Hanley*.

[72] Which, it is maintained, are not synonymous.

For lawyers, an argument is a set of premises designed to support a final statement or conclusion. Partisanship of the physician to the side that called him, viewed in this light, is in fact partisanship to his professional opinion; that is why he would have been called by the side which in fact called him. The insidious art of the lawyer is to ask questions which advance premises which the witness accepts. Through a chain of inferences, these premises are ultimately used to support a final premise. This empahasises the expert's role as pawn of the law or as a pawn of a particular lawyer.

The consequences for the medical profession are serious. In the examination, cross-examination and re-examination process, the acceptance of lay evidence threatens professional solidarity and control over expertise. What the lawyer wants is an expert at being a witness who is already an expert at being a medical practitioner. This emerges as potentially pivotal with regard to who is in control. In the nineteenth century with a more guild-oriented approach to medical practice, there was at times outrage when laymen offered opinions on occupational matters. This was significant of a reaction to an affront in which occupational skills were, and to an extent continue to be, seen as non-transferable.[73]

Privileges and protection were initially *granted* to professional groupings by government and indeed by society itself, but moral issues remain at times individual issues with the difference being one between what a professional does and what the profession does.[74] Professional ethics as a voluntary code of practice accepted *within* the profession may not be the same as judicial or statutorily imposed codes of conduct and behaviour. In the legal encounter the parallel discourses of law and medicine must operate simultaneously. Both professions will have developed their own individual jargon for homogeneity and exclusivity, which may not be understood by the other side. This is bound to lead to uncomfortable exchanges in court.

As the power of witnessing slips from the grasp of the medical profession, naturally its members may seek to entrench that power. The medico-legal committee of the Australian Medical Association, for example, is considering ways of using 'accredited' medical witnesses to give evidence at trials involving charges of negligence and criminal behaviour so that cases

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[73] Johnson 57. Consider, in this light, the use of lay evidence in the inquiry into legal causation. Cf. 4.4.

[74] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, [1957] 2 All ER 118 and consider what has been argued on the *Bolam* test in preceding chapters.

do not 'degenerate into ... battles of the experts.'[75] This list of experts, compiled by the specialist colleges, would be designed to 'keep bad science from the courts.'[76] But is this not merely an elaborate form of laager psychology in which the courts are intimidated by their own medical ignorance into being less tolerant, as *Wednesbury* unreasonable, of the views of those on the list than of those excluded from it?[77]

The court will use the medical facts, along with the plaintiff's evidence, to establish whether the failure to warn of the material risk was unreasonable - or indeed whether the plaintiff's assertion as to materiality is reasonable in the circumstances and given the medical evidence.'[78] This is a reaction to the gradual shattering of the myth of the community of equal competence which generated public trust in the medical profession.

The medical profession is used by the law to appraise the court of medical facts and opinions. By holding the defendant's omission non-negligent, a witness may be accused of being partisan to defender or pursuer. However, because of what has been said about the court's acceptance or rejection of expert testimony as implausible or not credible, it would be a more cogent argument to contend that it is the policy of the courts in a particular jurisdiction which guides the use of expert evidence and, hence, the protection (or not) of the medical profession. This will become apparent from a consideration of how the courts handled the evidence in the disclosure cases with which this thesis has been dealing.

5.4. INFORMED CONSENT CASE LAW

In *Canterbury v Spence* in America, the court held that the standard of disclosure should be one demanded by law rather than one which physicians may impose upon themselves.[79] The effect of this judgement was to remove from the medical community the power to determine standards

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[75] Christopher Zinn (1995) 311 *BMJ* 709-10.

[76] The Lord Chancellor did say that this principle should apply to solicitors too; i.e. only solicitors who know about medical negligence should be allowed to take such cases on legal aid. See the Lord Chancellor's Department consultation paper *Access to Justice with Conditional Fees*, March 1998, 3.15 – 3.19.

[77] This should be contrasted with the system in Denmark which is based on Insurance. See Segest, E. 'Legal Aspects of Cases of Medical Malpractice in Denmark.' (1993) 12 *Medicine and Law* 617-25. This thesis, however, is concerned with the common law of negligence.

[78] *Associated Provincial Picture Houses Ltd v Wednesbury Corp.* [1948] 1 KB 223 in which it was held (at 226) that, 'unreasonableness has to be established but it is for the court to exercise its own judgement on the facts established.'

[79] 464 F.2d 772 (1972).

of practice, and hence to reduce the weight of the doctor's evidence. When considering the 'materiality' of information, the court imposed a patient-centric standard.[80] This meant that, as the court put it,

> 'Of necessity, the content of the disclosure rests with the physician. Ordinarily it is only he who is in a position to identify particular dangers; always he must make the judgement, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude what the plaintiff would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react.'[81]

The doctor will have to speak to this issue in court. For the defendant's success in the case, the court would have to be persuaded on the evidence that the defendant was justified in assuming, on the basis of his knowledge of the patient and through clinical intuition, that the undisclosed information would not have been important to the patient.

However, the court went on to note that from 'these considerations', the court would be able to formulate the requisite legal standard of disclosure. That standard would not be 'subjective as to either the physician or the patient,'[82] but was to be an objective assessment. The court cited with approval an academic article to hold that a risk is material,

> 'when a reasonable person, in what the physician knows or ought to know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.'[83]

The only way the court can assert what a physician actually knew would be to consult his notes or to ask him. He would be unlikely to incriminate himself by answering that he knew the patient would deem a certain risk to be significant. For this reason the court would ask whether the physician *ought* to have known. The patient's evidence will be important here, but the very fact that the case has come to court indicates that the patient is asserting that the physician ought to have known of that plaintiff's information needs.

To establish what the physician ought to have known, the court will need to hear from

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[80] Cf. introduction to 3.3. However, it was noted in Chapter 4 (4.2.) that this standard varies among states in America. This particular case has been chosen because it is the case which is most cited by scholars in this field when they consider the 'American doctrine'.

[81] *Canterbury v Spence*, 787.

[82] Ibid.

[83] Ibid. The court cited Waltz & Scheuneman, 'Informed Consent to Therapy', 64 *N.W.U.L.Rev.* 628, 640 (1970). Cf. 3.3.

experts from both sides. These experts would say what they would have done in the same situation. It is a question for the finder of facts[84] to determine whether knowledge of a particular risk would have resulted in a decision against treatment, but hindsight renders this question a hypothetical one.[85] For that reason the court opted for a more objective test - that is what a prudent person in the patient's position would have decided had they been informed of the risk.

In the normal course of malpractice litigation, the patient will bear the burden of establishing, through expert testimony, that the physician's course of action departed from medical custom; this facet of negligence litigation was overturned in *Canterbury*. The court did so in order to cater for the test for materiality and that for legal causation. The court noted that experts are essential to provide the court with the facts concerning the therapy and the risk, as well as facts relevant to factual causation, but argued that the objective test renders experts less useful in disclosure cases than in cases of negligence *simpliciter*.

Indeed, the court held, 'It is evident that many of the issues typically involved in non-disclosure cases do not reside peculiarly within the medical domain.'[86] The court held that lay witnesses can establish the elements of the case and, more particularly, 'Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision.'[87] If, as the court put it, 'medical facts are for medical experts' and 'other facts are for any witnesses', the role of the expert witness in disclosure cases would appear to have been diminished. This is what the doctrine of informed consent decrees.

On the basis of *Canterbury*, it is possible to argue that the more patient-centric the tests for negligence in disclosure cases, the less decisive will be medical expert testimony. Further, that expert testimony will always be necessary to speak to the medical facts. This means that the inquiry into factual causation will, as we saw in the last chapter, hinge on medical evidence. Legal causation, however, does not necessarily require a medically qualified witness. It would seem, therefore, that those jurisdictions that adopt the doctrine of informed consent as

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[84] In *Canterbury v Spence* at 788 the court held that, 'Wherever non-disclosure of particular risk information is open for debate by reasonable-minded men, the issue is for the finder of facts.'

[85] 790. Cf. 3.3. on materiality and Chapter 4 on hypothesis in the causation inquiry.

[86] 792, again citing Waltz & Scheuneman. Ibid.

[87] Ibid.

descriptive of the standard of care, will have less use for the medical expert, other than in the establishment of factual causation. Our inquiry will, once again, follow the geo-chronological route of the doctrine itself.

5.4.1. CANADA

The Canadian case law supports the above contention. *Marshall v Curry*[88] was an assault and battery case brought before disclosure cases were litigated in negligence.[89] The defendant removed the plaintiff's testicle without consent during a hernia operation. This case serves as an example of the use of the defence of necessity: no action would exist given that the belief that the organ should be removed was reasonable. This is a matter of medical evidence alone. In *Marshall* the evidence supported the finding that there was neither express nor implied consent, but the evidence also established necessity as a question of medical fact that was also supported by the plaintiff's best medical interest.[90]

The law had yet to clarify the position in respect of disclosure cases. *Murray v McMurchy*[91] continued the debate on medical evidence as useful in establishing matters of medical fact. The issue was similar to that in *Marshall*: the justification for tying the plaintiff's fallopian tubes without her consent during a caesarean section. *Murray* confirmed the position in *Marshall* on necessity and life-preservation, but extended the ruling to hold that a surgeon is not entitled to act when a procedure, for which there is no consent, is merely convenient. The justification given was that there were tumours in the walls of the plaintiff's uterus; but medical evidence established that these would pose a threat only in the case of a further pregnancy and the tying of fallopian tubes was not the only way to prevent that occurrence. Indeed, Mcfarlane J held,

> 'The evidence is that this is, to use the words of a witness called for the plaintiff who is a specialist in gynaecology and obstetrics "not customary but common for cause".'[92]

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[88] [1933] 3 DLR 260.

[89] Cf. Chapter 1 generally.

[90] Ibid. 275. Medical evidence supported the finding that, 'the defendant after making the incisions on the plaintiff's body, discovered conditions which neither party had anticipated, and which the defendant could not reasonably have foreseen, and that in removing the testicle he acted in the interest of his patient and for the protection of his health and possibly his life.'

[91] [1949] 2 DLR 442.

[92] Ibid. 443 and 445 at which the evidence was discussed.

Medical evidence is used to establish medical facts which are based on common experience. It was held that the evidence established only that the tumours *might* constitute a hazard and that that would speak to quantum rather than to merits - another area in which medical evidence will be central.

The court uses both medical and lay evidence to establish what happened in both the consultation and the procedure itself. The court in *Kelly v Hazlett*[93] had to consider a scenario closer to what we know as the informed consent scenario. The issue was the performance of an osteotomy; the procedure had been explained only in broad terms, while the risk of stiffness to the elbow had not been disclosed. The court used medical expertise to appraise itself of what happened,[94] of the level of risk involved,[95] of cause in fact[96] and of materiality.[97] It is this last element that is of interest here.

The court had used the evidence of both plaintiff and defendant as a guide to what the plaintiff would have done had he known of the risk. The more persuasive evidence was held to be that of the defendant and the defendant's witness: that the procedure followed was in accordance with medical custom. The court held that there had not been negligence because custom had been followed. Morden J still dealt with the issue of materiality to hold that,

> 'The evidence relating to the plaintiff's consent to this operation is somewhat sparse but I am satisfied that she knew beforehand the basic nature of this operation and whatever failure there may have been on the defendant's part to go into its attendant risks was justifiable as a matter of medical judgement ... and, further, I am of the view that if he had explained the risk of refracture she probably would have agreed to the operation.'[98]

This is a matter of using medical evidence to establish the plaintiff's likely state of mind and, hence, hypothetical actions which speak to legal causation. This was expressly stated as a policy matter, paving the way for the decision in *Hopp v Lepp*.[99]

Hopp v Lepp concerned the duty to disclose that there were specialists in Calgary who would be on hand to deal with resultant complications should the operation be performed there.

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[93] [1976] 75 DLR (3d) 536.
[94] By looking at the medical records. Ibid.
[95] Ibid. 551.
[96] Ibid. 552.
[97] Ibid. 559.
[98] Ibid. 556.
[99] [1980] 112 DLR (3d) 67.

This case highlights the difference between factual and legal causation by supporting the Court of Appeal judgement which had held that, '[the undisclosed facts] need not concern matters which directly cause the ultimate damage if they are of a nature which might influence the judgement upon which consent is based.'[100] This indicates that medical evidence can prove useful to an assessment of materiality of risk, and hence legal causation, though that evidence does not decide the case.

Considering the test in *Canterbury* - and in fact citing that case - Laskin CJC accepted the view that a risk is material if the physician knows or should know that the plaintiff would attach significance to that particular risk. He went on to hold that, 'No doubt, this invites a finding of fact upon which medical evidence of the judgement to be exercised would be admissible but not determinative.'[101] So, when the desire for information on the part of the patient is expressed as an expectation of the physician, medical evidence will be useful, though will not in itself dispose of the case.

This was the vantage point from which the court could view the issues when deciding *Reibl v Hughes.*[102] The case involved the risk of a stroke from the repair of an artery in the plaintiff's neck. The court had to consider whether an objective or a subjective test should be employed for legal causation and materiality. This has been discussed in preceding chapters. What is important at this point is the extent to which medical evidence proved useful in answering the 'apparent subjective' test actually adopted in that case. Having debated the pros and cons of the various tests available, and having decided to take into account the 'patient's particular position, one which will vary with the patient,' and to assess it 'objectively in terms of reasonableness', Laskin CJC went on to consider the evidence.[103]

He held that the crucial evidence was not that of the medical experts called, but that of the plaintiff. Having assessed this evidence and prioritised it over medical evidence, the court found the latter evidence useful for an understanding of the 'reasonable patient in this patient's position.' In cross-examination the court learns what dialogue took place between patient and physician. To that information is added any verification of matters of fact; this is where experts

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[100] Ibid. 78.
[101] Ibid. 80.
[102] [1098] 114 DLR (3d) 1.

come in.

This position has been endorsed in *Arndt v Smith.*[104] What is important is that the influence of the medical expert has been diminished by the adoption of a test for materiality which favours the patient over members of the medical profession. It has been argued in this thesis that the test in Australia is the most patient oriented among those discussed. It will therefore be interesting to see whether or not the importance of the medical expert has been more expressly diminished in that jurisdiction.

5.4.2. AUSTRALIA

It will be remembered that in *Ellis v Wallsend District Hospital,*[105] Australian courts adopted a more patient-centred approach than that adopted in *Sidaway.*[106] In *Ellis* the court held that medical opinion and standard practices are important, but as a mere guide to the court. This position was taken up in *Rogers v Whitaker*, where there was also evidence from similarly reputable medical practitioners that they would not have warned of the risk. But the picture was less clear before *Rogers.*

In *F v R*[107] the court held that a failure to warn of the remote possibility of a tubal ligation being unsuccessful was not a negligent breach of the standard of care.[108] On the scope of the duty of care, the court debated the approaches considered in *Canterbury v Spence* and in *Reibl v Hughes* and noted that in *Sidaway* in England the 'extent of duty to advise and disclose will be affected by the surrounding circumstances' and will be guided by an assessment of reasonableness on the part of the doctor. For this, 'much assistance will be derived from evidence as to the practice obtaining in the medical profession.'[109] On this point the Supreme Court of South Australia sided with the decision in *Reibl v Hughes*, saying that,

> 'To allow medical evidence to determine what risks are material and, hence, should be disclosed ... is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that

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[103] Ibid. 17 et seq.
[104] [1995] 7 Med LR 108.
[105] (1989)17 NSWLR 553, cited in Giesen & Hayes at 106.
[106] Cf. 3.2.2.2. and 3.3.2.
[107] (1983) 33 SASR 189.
[108] Ibid. 191. This was the first Australian case to consider the informed consent scenario.
[109] Ibid. 193.

duty.'[110]

The court noted that practices may develop within a profession more because of convenience than altruism and that the court had an obligation to scrutinise these practices. In *F v R*, medical evidence established that some practitioners would disclose and some would not. While the trial judge had held that failure to disclose the risk was negligent, the Supreme Court held that non-disclosure did not amount to negligence. In this case the respondent patient averred that had she known of the risk, she would have elected another procedure. However, medical evidence caused King CJ to hold that,

> 'If there had been a medically acceptable choice between tubal ligation with a slight risk [0.5%-1%] of failure and another medically acceptable operation with no risk of failure, I would have held that there was a duty to volunteer full information to enable an intelligent choice to be made.'[111]

Despite expressly citing the patient's right to information as grounds for disclosure, the test for legal causation[112] was not satisfied by the respondent patient on the ground of medical evidence. Finally, King CJ held that it is for the court to decide what the responsible doctor would have disclosed in the circumstances. This case was one which still adhered to a *Bolam*-style test, although took the patient's view into account.[113] Considering *Bolam* and *Chatterton v Gerson*,[114] Bollen J held that because some gynecologists would warn and some would not and because the risk was a very slight one,[115] the appellant was justified in not disclosing that risk. Medical evidence is essential in establishing the facts on which such decisions are based.[116]

Gover v State of South Australia and Perriam[117] is a case which also involved the use of expert evidence to establish the extent to which a practitioner conformed to the practice of members of the medical profession. This judgement also questioned whether the plaintiff bears

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[110] Ibid. 193-194 (*Reibl v Hughes*, Ibid. 13.)
[111] Ibid. 196.
[112] i.e. that had she known of the risk she would have elected an alternative procedure
[113] As in England; Cf. 5.4.4.1.
[114] [1981] 1 All ER 118.
[115] i.e. that is not a 'real risk inherent in surgery'.
[116] Ibid. 206.
[117] (1985) 39 SASR 543.

the onus of proving that had they known of the inherent risk, they would not have undergone that procedure.[118] Cox J was able to consider both *F v R* and *Sidaway* as to the duty of disclosure. He approved of a passage in *F v R* in which King CJ had held that, 'The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by law.'[119]

To establish this, the court heard from medical experts on how they thought Dr Perriam should have acted and on whether there is a responsible body of ophthalmologists who might have acted in the same way. The court observed that 'the extent to which the courts are to be influenced in these cases by a prevailing professional practice remains a vexed question in the common law world',[120] and noted the differences in approach on either side of the Atlantic before again approving of the decision in *F v R*. This meant that reasonableness was a question for the court which was to be guided by prevailing medical practice.

For this the court heard from nine experts, of whom five dealt with the subject of liability. These witnesses examined and commented on the contents of the plaintiff's medical notes and about the significance of the appearance of various symptoms, diagnosis, prognosis and preferable forms of treatment. On these points the experts were not always in agreement, so comprising a divergence of medical opinion. What the witnesses did have in common was the task of explaining to the court the medical facts which, as Cox J explained, were 'quite unfamiliar to [him].'[121] Armed with this information, he was able to hold that the surgery was itself justified and indeed that it was performed competently.

The duty of disclosure, however, is determined with the aid of 'opinion evidence' and is hence more a matter of conjecture than medical fact. This is because while medical texts may reveal the extent of a particular risk, they will seldom, if ever, issue guidelines at to whether certain risks should be disclosed. In *Gover* the plaintiff complained that the risk of complication

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[118] The risk in question was that of blindness as a complication following an upper lid blepharoplasty.
[119] Ibid. 552.
[120] Ibid. 553.
[121] Ibid. 555.

was not explained to her and that alternatives to surgery were not explained. These alleged omissions were dealt with together because they were interrelated. It was held on the basis of his own evidence that Dr Perriam had not mentioned complications because he saw no need to do so; he had also not informed the patient of alternative procedures. It remained for the court to establish whether this omission was a negligent one.

Again there was disagreement among experts regarding the propriety of non-disclosure. The court considered in some detail each of the complications, particularly the one which occurred; the opinions of experts and the medical literature were canvassed on each.[122] The court found that some risks were to be disclosed on the basis of their severity (blindness). This finding was based on the court's assessment of reasonableness as established by a consideration of the medical evidence given by the experts. However, it was found that the risk that eventuated was not subject to a duty of disclosure, because of its relative improbability. For this reason no liability would follow because negligence unrelated to injury is not actionable.

That said, the plaintiff went on to argue that the negligent failure to warn of a risk was material precisely because had she known of that risk she would have refused surgery and hence would not have suffered injury.[123] At that point Cox J considered the subjective, objective and apparent subjective tests in *Bolam* and *Chatterton* in opposition to those in *Canterbury* and *Reibl*. He noted that when *F v R* was heard, the trial judge did not have the benefit of the decision in *Reibl v Hughes*, but that by the time of the instant case, the *Reibl* judgement had been given. Cox J followed the full court decision in *F v R* and considered what the reasonable person in the plaintiff's position would have done given the information. Supported by the law of negligence, the court applied a subjective test and based the decision on the plaintiff's evidence. This evidence will be hypothetical and will depend on the plaintiff's honesty[124] and, most importantly, will be non-medical in nature.

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[122] Of importance here is the dismissal of evidence of academic articles published after the surgery was performed.
[123] Ibid. 564.
[124] Ibid. 566.

By this stage the court will be armed with medical facts, the evidence of the plaintiff and a body of legal principle. Cox J considered the ramifications of the subjective test in relation to the hindsight of the patient-plaintiff. Based on her evidence, demeanour in court and general opinions on undergoing surgery *per se*, he found that her actions would not have differed from those of the reasonable patient in such a situation and, hence, that it was more likely than not that she would have undergone surgery. This meant that her evidence was more important than that of the medical experts, but would be tempered by the total body of evidence before the court.[125]

It would appear that Australian law is clear on which evidence is useful to what end and at which point in the judgement.[126] This follows the same rationale as that in Canadian courts. Medical evidence is more useful in establishing negligence and factual causation than it is in establishing legal causation. This was the position inherited by the court at the time of *Rogers v Whitaker.*[127]

In that case Mason CJ said that he was both obliged and indeed wished to follow *F v R*, because that was also an 'informed consent' case. Again the position in Canada was juxtaposed against that in England, with the court noting that while the Canadian courts had adopted and adapted the test, the English courts had declined to do so. He separated cases of alleged negligence *simpliciter* from those involving disclosure, and then set out the test for negligence. On the *Bolam* test Mason CJ said that in matters of medical evidence there is scope for the 'genuine disagreement' among experts which was in evidence in the *Gover* case. In considering the divergence of tests exemplified in English and Canadian courts, he sided with Lord Scarman's dissenting judgement in *Sidaway* - a dissent which agreed with the position established in *Canterbury v Spence* in America.

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[125] It is noteworthy that at one point in the judgement the plaintiff admitted to having lied: for a discussion under the head The Plaintiff as Witness, see 553-555.

[126] This case was applied in *Young v Northern Territory of Australia, Albert Raymond Anderson and Lorraine Evans*, No. 46/1987, Supreme Court of the Northern Territory of Australia, 15-28 October 1991, Judgement 22 May 1992, Lexis.

[127] [1993] 4 Med LR 79.

The standard of care in Australia in matters of alleged medical negligence remains the raised standard of the medical professional of analogous skill and qualification. However, Mason CJ said that, 'that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade.'[128] The *Bolam* test had been discarded by the judgement in *F v R* and hence medical evidence became something which served as a useful guide rather than as disposing of the case. This is because the paramount consideration is the principle that a person is entitled to make their own decisions about their bodily integrity.

Mason CJ noted that the approach of Lord Scarman in *Sidaway* was similar to that of King CJ in *F v R* and was, in his view, the correct approach. Because disclosure matters involve information and because patients' rights are implicated in the verbal interaction between doctor and patient, a different standard was held to be applicable to disclosure cases.[129] For this reason, 'it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.'[130] Perhaps more to the point, Mason CJ said,

> '*whether* the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment ... is not a question the answer to which depends upon medical standards and practice.'[131]

This introduces the test for legal causation. As it was in Canada and based on the patient's right of self-determination, medical evidence served as useful to the court. It is the Court's task to determine reasonableness on the part of the doctor with regard to the standard of care. The court must also assess reasonableness on the part of the patient, based on the plaintiff's evidence, in order to establish legal causation. Medical evidence is useful in informing the court of current trends and of the medical facts, including factual causation. After that it is for the court to determine whether the presence of information on the risk - in this case of sympathetic ophthalmia - which eventuated would have made any difference to the decision of the patient to undergo the treatment proposed - in this case cosmetic eye surgery.

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[128] Ibid. 82, here citing *Florida Hotels Pty Ltd v Mayo* (1965) 113 CLR 588, at 593, 601.
[129] Cf. 6.3.1. on the patient's right as a rationale for adopting the doctrine of informed consent.
[130] Ibid. 83.
[131] Ibid. 83. Emphasis in original.

Because in Australia the test for legal causation and for materiality has been a subjective one since before the judgement in *F v R*,[132] the court relied more on an assessment of the credibility of Mrs Whitaker's evidence, than on an assessment of the available evidence of medical practice. On that basis it was held that because of a general concern for the health of her 'good' eye, the reasonable ophthalmologist could be expected to translate that into an expectation on the part of the patient, of a warning that there was an inherent risk of developing sympathetic ophthalmia. This is because that risk was material to this patient as assessed by the court on the basis of her evidence.

The Australian position confirms the thesis that the more patient-centric the legal tests of a particular jurisdiction, the less important will be the evidence of the medical profession. The South African position, however, is perhaps the exception that proves the rule. There the position is undoubtedly patient-centric, yet medical evidence is of disproportionate importance.

5.4.3. SOUTH AFRICA

For this, it will be instructive to return to those disclosure cases that preceded *Castell v De Greef*. As early as *Van Wyk v Lewis*[133] it was clear that medical evidence established the medical facts used by the court to establish liability because, as the court put it, negligence 'can never be disentangled from the facts.'[134] In *Richter and another v Estate Hammann* the court held that,

> 'in reaching a conclusion a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'[135]

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[132] (1982) 33 SASR 189.
[133] 1924 SA 439.
[134] Ibid. 447.
[135] 1976 (3) SA 226, 232G. *Blyth v van den Heever* 1980 (1) SA 191 supports this position and asserts the competence of the court to assess medical evidence on the ground of reasonableness.

The *Richter* case concerned the advice of the doctor on whether or not to have a particular surgical procedure;[136] this advice included information on risks and alternatives. The court held that the standard was to be assessed relative to the reasonable medical practitioner. The court had recourse to medical evidence in order to establish a usual practice and then to assess whether or not that practice was followed by the defendant. This *Bolam*-style standard proved useful to the defendant in that case.

Even though it was unnecessary so to do, the court discussed causation and cited the test for legal causation in the following way: '... this would have entailed proof at least of the fact that if Dr. Hammann had told her that the incidence of risk was as low as set out above, she would still have refused the operation.'[137] The court would have to take the plaintiff's evidence into account; Watermeyer J expressed scepticism of doing so in the light of the plaintiff's hindsight, saying that he felt that 'very little weight should be attached to an *ex post facto* statement of that nature.'[138]

In *Castell v De Greef*[139] the court introduced a patient-oriented standard of care to disclosure cases in allowing the *volenti* defence to be led. This decision attributed a disproportionate importance to medical evidence in what has become a patient-centric jurisdiction. It will be remembered from a discussion of *Castell v De Greef* in chapters three and four, that this requires the establishment of two essentially medical facts: that no warning was in fact given (attested to through practitioners' notes) and that the undisclosed risk factually caused the injury suffered. This forms almost the whole of the inquiry. Conflict between matters of fact and an assessment of materiality has already been discussed;[140] for now it is important to consider the court's treatment of the evidence.

Medical evidence was necessary to the court's understanding of the cosmetic surgery performed and the level of risk of necrosis involved in that surgery, 'to determine what risks inhere in or are the result of particular treatment ... and might have a bearing on their

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[136] Bilateral phenol and epidural blocks for coccygeal pain.
[137] Ibid. 233.
[138] Ibid.
[139] 1994 (4) SA 408.
[140] Cf. 3.3. Discussion will continue in 5.5.2. and 6.2.

materiality ...'.[141] Because the defendant led the plea of *volenti non fit injuria* and because that defence plea was admitted, the court had simply to ask whether, as a question of fact, the plaintiff knew of the risks involved. This was the case because, as the court held, necrosis was a material risk as assessed by the subjective test gleaned from *Rogers v Whitaker*. To adopt such an approach the court dispensed with the *Bolam* test and distinguished cases in which that test had been used. This rendered expert medical evidence less conclusive than it had hitherto been.[142] The court sided with the judgement in *Reibl v Hughes* on this point.

The whole matter, thereafter, 'involved a conflict of fact.'[143] To establish the relevant facts, the court will call experts to help interpret the medical notes. It will also call both plaintiff and defendant to recount what transpired between them in the consultation prior to surgery. It will then assess the credibility of each witness and the reasonableness of the evidence of each witness. On this point, and adopting a patient-oriented policy, the court found against the plaintiff.

As regards lay evidence, of particular interest is the inference drawn by Scott J in the court below and agreed with by Ackerman J. The plaintiff's husband was not called to give evidence about what was said at the consultation between doctor and patient., even although he was present at that consultation. The inference drawn was that the plaintiff's testimony – that she was not warned of the risk which the court had held to be material – lacked credibility because support it might have been given, had been withheld.

What is apparent from a discussion of the use of expert evidence in the three jurisdictions which have adopted the doctrine of informed consent (to a degree), is that the more patient-oriented the various tests for negligence and causation, the greater will be the importance of the evidence of the plaintiff over the evidence of witnesses for the defendant medical practitioner. This is a question of credibility, internal consistency and of the exclusion of hindsight. That this is the case will become even more apparent through a consideration of the most medically-oriented jurisdictions covered by this thesis.

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[141] Ibid. 426.
[142] Ibid. 419.
[143] Ibid. 427.

5.4.4. BRITAIN

The general principles governing the use of the medical expert in negligence cases have already been discussed.[144] We know from previous chapters that British jurisdictions adopt a stance unlike the other jurisdictions discussed and do not use the doctrine of informed consent to describe the standard of care in disclosure cases. Looking at English and Scots law will reveal that the use of expert testimony is used in the same way in those jurisdictions and is different from how experts are used in Canada and Australia. It will also be possible to assert that this is because British jurisdictions have not adopted the doctrine.[145]

5.4.4.1. ENGLAND

The *Bolam* judgement set out the test still used in England in respect of negligence cases based on non-disclosure of risks. We must remember that the *Bolam* test is a rule of evidence rather than a rule of law; it is about how the law is able to treat the evidence. In the *Bolam* case it was held that where the medical evidence showed that there was more than one body of competent medical practice, and that the defendant followed one of them, no negligence could be found. If the defendant can find an expert who represents a responsible body of medical opinion and an expert to support that defendant's omission, this evidence will admonish him. McNair J put it to the jury in the following way:

> ' ... it is not essential for you to decide which of two practices is the better practice, as long as you accept that what [the defendant] did was in accordance with a practice accepted by responsible persons; but if the result of the evidence is that you are satisfied that his practice is better than the practice spoken of by the other side, then it is a stronger case.'[146]

It is not a matter for court or jury to weigh up the practices of the profession; their task is to assess the defendant's omission relative to the medical community. The court in *Bolam* cited the evidence of experts and on that basis no negligence could be found. Subsequent cases in English law have adopted the same approach. However, because of a shift in the outcomes of cases since *Bolam*, simply by looking at the use and significance of the medical expert, one can

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[144] In 6.3.

[145] The use of expert evidence in Britain will also form the basis of arguments to be made in Chapter 6, which will concern possible developments in disclosure case law.

[146] *Bolam v Friern Hospital management Committee* [1957] 2 All ER 118, 122.

track judicial movements within consent law.[147]

In *Chatterton v Gerson*[148] the court considered the test of liability in circumstances in which the doctor had explained to the patient the nature of the operation in broad terms. The case had to do with whether the action lay in trespass or in negligence.[149] It was held that the action lay in negligence because of the presence of general consent. Accordingly, the *Bolam* test came into play. The court questioned Dr Gerson's usual practice concerning the giving of a warning of attendant risks, by asking both parties to try to recall what had taken place in the consultation between them.[150] After that, medical evidence was used to piece together the pertinent medical facts. On that basis, the court was able to hold that the injury of which the plaintiff complained was not related to the procedure carried out. The plaintiff's allegation was that her consent was vitiated by the defendant's failure to provide information on the attendant risks involved in that procedure. On the *Bolam* standard there was found to be no negligence; even if negligence had been found, the medical evidence would not have established legal causation because she would still have undergone surgery.[151]

At the level of proof of duty and fault, *Hills v Potter*[152] is interesting from the point of view of the measurement of the standard of care through the use of expert evidence. Adopting the test set out in *Bolam* and in *Hunter v Hanley*, the court reaffirmed the ruling in *Chatterton* to hold that the doctor was not negligent because, in his omission to inform, he had followed a practice accepted as proper by a responsible body of skilled medical practitioners.[153] To establish that this was the case, the court would have recourse to the evidence of representatives of that responsible body; the court had to 'consider the legal standard applicable in this case to the first defendant's conduct';[154] again the court assessed the standing, within the medical community, of the witnesses called; again the court had to look at the internal consistency of the evidence given.

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[147] Cf. 3.3.4., 4.3. and 6.3.
[148] [1981] 1 All ER 257.
[149] This was discussed in Chapter 1.
[150] [1981] 1 All ER 257261 et seq.
[151] Cf. 4.3.
[152] [1983] 3 All ER 716.
[153] Ibid. 720*f-h*, 727*e*–728*a* and 729*a*.
[154] Ibid. 720*e*.

The most important disclosure case in English law remains the *Sidaway* case.[155] It's importance to the current chapter lies only in respect of the standard of care. The court considered at some length whether or not to adopt the doctrine of informed consent. Having decided not to do so, the case followed the same route as that followed in *Hills v Potter*, *Chatterton v Gerson* and *Whitehouse v Jordan*: it was a matter of determining whether the surgeon had been negligent in his omission to inform the patient of the inherent risk of spinal damage resulting from an operation to her neck.

The case was complicated by the fact that the surgeon had died while the case was being taken through the appeals process and by the fact that the medical records were inconclusive in respect of what communication had taken place between surgeon and patient. The court therefore had only the evidence of the plaintiff on the nature and extent of the warning given.[156] In that case medical evidence was useful to the court in establishing factual causation (even though this was not necessary) and in educating the court in the vagaries of spinal damage during neck surgery.[157]

Indeed, as Lord Bridge put it, 'Expert medical evidence will be needed to indicate the nature and extent of the risks and benefits involved in the treatment ...'.[158] At the time he was considering the judgement in *Canterbury v Spence*, in which it had been held that 'Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision.'[159] Lord Bridge went on to note just what is being noted in this section: that, as he put it, 'In English Law, if this doctrine were adopted, expert medical opinion as to whether a particular risk should or should not have been disclosed would presumably be inadmissible in evidence.'[160] The contrary position is the one in force in England because the doctrine was not adopted and the *Bolam* test was upheld. Lord bridge went on to note that,

> 'the issue whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided on the basis of expert medical evidence,

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[155] [1985] 1 AC 871.
[156] Ibid. 874D-F.
[157] Ibid. 877.
[158] Ibid. 898G.
[159] Ibid. 898G-H, quoting from *Canterbury v Spence* at 792.
[160] Ibid. 898H-899A.

applying the *Bolam* test.'[161]

In *Sidaway*, the medical witnesses were agreed that the duty of care required a warning, but they were not in agreement on the extent of the warning required.[162] The court was obliged to implement the *Bolam* test because it was held to be applicable in disclosure cases as well as to matters of diagnosis and treatment. Even Lord Scarman, dissenting as he was, agreed that, 'His decision not to warn her of the danger of damage to the spinal chord and of its possible consequences was one which the medical witnesses were agreed to be in accordance with a practice accepted as proper by a responsible body of opinion among neuro-surgeons.'[163]

The court has followed the same route in subsequent analogous cases. In *Gold v Haringey HA*,[164] the evidence established that a substantial body of responsible doctors would not have given a warning of the risk of failure of a sterilisation operation. In *Gold* the court cited and approved of both *Bolam* and *Sidaway*.[165] In *Sidaway*, the materiality of the risk was considered from the point of view of the reasonable practitioner rather than the reasonable patient.[166] Accordingly, medical evidence carries more weight in assessing the standard of care than it does in jurisdictions in which the test for materiality is more subjective.

This is clearly not something which would occur in the jurisdictions already covered in this section, because those jurisdictions do not adopt a test like the *Bolam* test in disclosure cases. Indeed, those other jurisdictions, particularly Australia and Canada, adopt a test for the standard of care in which medical evidence is useful rather than decisive.

We will see that medical evidence will play a less important role in England in cases in which the plaintiff establishes a breach the standard of care and then has to go on to prove causation. In the 'erosion cases' the importance of expert evidence resurfaced in the causation inquiry. Cases in which the duty of care facet has been proven in *Bolam* terms thereafter become matters of proving causation, as with any negligence or disclosure case. Medical

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[161] Ibid. 900C-D.
[162] Ibid. 880.
[163] Ibid. 882H-883A.
[164] [1987] 2 All ER 888.
[165] [1993] 4 Med LR 151, although the judgement was handed down in 1987. A similar approach was apparent in *Blyth v Bloomsbury HA*.

evidence will be vital in factual causation - in establishing a connection between the omission and the injury. But what of legal causation?

To appreciate the approach of English courts to legal causation, we will need to look at cases in which the courts have decided that arguments on the standard of care fall in the patient's favour. It will also be instructive to consider cases in which the courts used expert opinion, in conjunction with the *Bolam* test, in respect of the balancing of clinical risks and benefits. This is because the test for causation was seen to be a subjective one in Chapter 4. It would be for the plaintiff to establish that he would not have undergone the treatment had he known of the risk involved. We will see that in those rare cases that reach that stage of the inquiry, English courts rely less on medical evidence than they do at earlier stages of the inquiry. This is because while the test for the standard of care is an objective, medically-based one, the test for legal causation is a subjective, patient-centered one, which uses medical facts.

Smith v Tunbridge Wells HA[167] concerned the negligent failure to warn a patient of the possibility of impotence and incontinence following the so-called Wells operation.[168] It was found that a responsible body of medical practitioners would have given such a warning – indeed that to give a warning was the *only* reasonable course of action.[169] On factual causation, medical evidence was used to establish that the impotence actually suffered was caused by the Wells operation itself. The test for legal causation was a subjective one: whether or not Mr Smith would have declined the operation had he known of the risk involved. Morland J said, 'I am entirely satisfied that if the risk of impotence had been explained to the plaintiff, he would have refused the operation.'[170] To arrive at this conclusion, he considered the plaintiff's age (28), family disposition (he was married) and the fact that he had already lived with the condition for eight years. For this, medical evidence was precisely the 'useful guide' for the courts that it had been in *Rogers v Whitaker.*[171]

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[166] Ibid. 893D-F. In his judgement, Lord Diplock noted that the duty of care was not divisible into component parts with different judicial tests to be applied to each part. See also Lord Bridge on materiality, Ibid. 897B.
[167] [1994] 5 Med LR 334.
[168] This case has already been discussed in 4.3. It remains to comment on the court's use of expert evidence.
[169] Emphasis in original, Ibid. 330, col. ii.
[170] Ibid. 341, col. i.
[171] Which was cited by the Queen's Bench in *Smith*.

A similar logic was put to use by Mr Justice Rougier in *McAllister v Lewisham.*[172] Again negligence was established; it was held that the evidence of the expert witness for the defence contained an inherent paradox in that the witness made no criticism of the surgeon's failure to mention the risk of sensory deficit, yet that risk stood at 100 per cent.[173] Weighing up the evidence and assessing its internal consistency, the judge was able to hold that 'those who say that the warnings given ... were inadequate are right and there has not been shown to me on the evidence any reputable body of responsible opinion to the contrary.'[174]

Rougier J called the causation inquiry the 'hardest part' because it involves hypothesis and hindsight. The evidence established that the operation was the factual cause of the injury. Then, as in any disclosure case, it fell to the plaintiff to establish that with the information, she would have declined the operation. Mrs McAllister's 'innate honesty' prevented her from speculating as to what she would have done had she known of the risks, but the court was able to make a finding in her favour nonetheless.

Indeed, the court considered the medical evidence in relation to Mrs McAllister's personality (sensible and independent-minded) and lifestyle (her job and the independence it gave her).[175] Medical evidence was used to establish that her medical condition was advancing slowly; that information was used along with the court's assessment of her personality and the plaintiff's assertion that she would probably have taken a second opinion had she known of the risk, to hold that this patient would have declined the operation.

When comparing, as we are, this case to those in Canada and Australia, what is notably absent from the judicial test is an assessment of the reasonable person *in the plaintiff's position.* This indicates that the test is that much more subjective in England than it is in Canada, but remains skeptical of the patient's hindsight. The next case casts this statement in a slightly more dubious light, because as in the preceding two cases, the court tried to disregard the hindsight of the patient. However, when trying to assess what a plaintiff would have done had he known of the risk, the court made greater use of medical evidence and the tendency of patients in similar situations. This suggests that the court tried to inject a little more objectivity into the test for

[172] [1994] 5 Med LR 343.
[173] Ibid. 352, col. ii.
[174] Ibid.

legal causation through a more objective assessment of the evidence. This occurs only if the subjective approach is unconvincing.

Newell and Newell v Goldenberg[176] involved a vasectomy operation which led to recanalisation and, hence, to a fourth pregnancy for the Newells. They alleged that had they known of the risk of recanalisation, Mrs Newell would have had a sterilisation operation too, so erring on the side of caution. After considering the views of experts called for both sides, Mantell J found the defendant negligent on the ground that,

> 'given knowledge of the risk, the only argument which can be offered against giving a warning is the concern that the confidence of the patient and his partner might be undermined with a corresponding increase in anxiety during and following the sexual act.'[177]

The judge was taking account of patient-centric factors in this assessment of the standard of care. The court then moved on to causation. True to the subjective test, the court would have to be satisfied that the Newells would have taken a different course of action had the information been given. On the subjective side of the inquiry, Mrs Newell asserted that had they known of the risk, she would have undergone a sterilisation operation. Mantell J observed that this statement was made with the benefit of hindsight; indeed that 'the operation on Mrs Newell only took place after these proceedings had been put in train.'[178]

For that reason, the court had to consider a more objective form of inquiry to resolve the causation issue. The court noted that the surgery on Mrs Newell was contraindicated on medical grounds and that would have outweighed arguments in favour of a joint sterilisation which was, according to expert evidence called by both sides, almost unheard of in medical circles. This case shows that medical evidence can be useful to the court in the inquiry into causation where too much reliance is placed on the hindsight of the plaintiff and, as argued in the previous chapter, shows a tendency towards a Canadian-style test at that level.

In *Lybert v Warrington HA*[179] the Court of Appeal[180] again had to consider a failed

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[175] Ibid. 353, col. ii.
[176] [1995] 6 Med LR 371
[177] Ibid. 374, col. i.
[178] Ibid. 374, col. ii.
[179] [1996] 7 Med LR 71.

sterilisation operation. It was concluded that insufficient warning had been given of the prospect of failure. Further, the court found that there was an 'inherent likelihood' that with a proper warning that a sterilisation may fail, the couple would have used other methods of contraception while they waited for the plaintiff to undergo a hysterectomy.[181] Lord Justice Otton drew this conclusion from the previous history of the plaintiff and from the fact that she had already undergone three caesarian section operations and had requested a hysterectomy to take place at the same time as the last of those three caesarian sections. She was advised that this would not be possible, so consented to a tubal ligation while waiting for a hysterectomy to be performed as a separate procedure.

This decision shows a return to a more subjective test, with medical evidence useful only if the plaintiff's testimony lacks credibility - by being based on hindsight, for example. In this case, there was no such lack of credibility and hence medical evidence of the consequences of a fourth caesarian section and, of course, of factual causation, was the 'mere useful guide' that the court found it to be in *Rogers v Whitaker.*

We will see in the next chapter that expert evidence and the points at which it can be used, form the basis of any speculation on possible developments in negligence law based on disclosure. Part of that chapter will comprise this sort of speculation based on what we already know of the current state of the law and on the decisions in the last four cases considered in this section.[182]

5.4.4.2. SCOTLAND

Scottish courts have led rather than emulated those English decisions in which patients proved successfully that disclosure did not conform to the standard of care demanded by the law and that this omission caused the injury complained of. Even so, there has been only one such case and this may have to do with the difference in the test in *Bolam* from that in *Hunter v Hanley.* However, from the argument in Chapter 3, this is unlikely.[183] Decisions are made based on

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[180] This is significant because the decisions in the previous three cases discussed were taken by the Queen's Bench Division.
[181] Ibid. 74, col. i.
[182] Cf. 6.3.
[183] Cf. 3.2.

cases that come before the courts in any jurisdiction. In the law of delict such cases will be based on the occurrence of injury. In other words, many factors will play a part in explaining why fewer 'erosion' decisions have been handed down in Scotland: for example, population size, attitude to litigation, quality of health care and the practice of defensive medicine. It is impossible to say that this is so simply because of a supposed difference in judicial tests, which has been argued to be an illusory difference.

Decisions which favour the patient are possible in Scotland. Even taking the test in *Hunter v Hanley* at its most stringent, it would be a matter of proving that the omission of the doctor was such that no other doctor would have made. While this may be difficult to establish, it is not impossible, as the case of *Goorkani v Tayside Health Board*[184] indicated. Medical evidence lost some of its importance when the inquiry turned to causation. But before we look at *Goorkani*, we might consider those cases which preceded it and involved the standard of care only. That standard is determined by applying the judicial tests in *Bolam* and in *Hunter v Hanley* in which medical evidence is of cardinal importance.[185]

One must bear in mind that *Hunter v Hanley*[186] preceded *Bolam* and it was the latter case which reformulated the test set out in *Hunter.* Unlike the *Bolam* test,[187] in *Hunter* the test is not exculpatory; rather it is one according to which negligence is established where a doctor committed an act or made an omission which no other doctor acting with ordinary skill would have made. As far as disclosure cases are concerned, *Bolam* is perhaps more comparable because that case concerned disclosure of risks, while *Hunter v Hanley* concerned negligence *simpliciter.*

However, it remains the case that in Scotland the test for negligence is taken from these two cases.[188] *Moyes v Lothian Health Board*[189] was a case that turned entirely on its facts. Lord Caplan commented on and approved of the judgement in *Sidaway.* In *Moyes* the pursuer suffered a stroke which was a risk inherent in an invasive diagnostic procedure known as

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[184] [1991] 3 Med LR 33.

[185] In *Moyes v Lothian Health Board* 1989 SLT 444, 449, Lord Caplan said, 'the appropriate tests to apply in medical negligence cases are to be found in *Hunter v Hanley* and *Bolam.*'

[186] 1955 SLT 213.

[187] Cf. 3.2.1. on the differences between these two tests.

[188] Ibid.

angiography. She alleged that the neurological professor who performed the procedure had negligently omitted to warn her that her hypersensitivity to the contrast medium led to an aggravated risk of a stroke.

Medical records and the evidence of hospital staff were used to piece together the patient's relevant medical history. Counsel for each side led expert opinion evidence from radiographers with expertise in angiography. Again, medical evidence helped the court establish the levels of risk applicable to the procedure in question and the fact that hypersensitivity to iodine does lead to an aggravated risk of neurological disorders, including stroke. On the facts, the defender had warned of the risk of stroke, but not of the *aggravated* risk. However, while the medical evidence established that the pursuer had suffered a stroke, it failed at proof to establish any previous hypersensitivity and, hence, this was not a possibility of which the surgeon could have been aware.

Two questions of fact were crucial to the pursuer's case: did she suffer a hypersensitive reaction and was she given a warning? Because the answer to the former was in the negative, answering the latter was unnecessary. Interestingly, Lord Caplan went on to contemplate the position were he to be wrong in this assessment. He considered that there was a duty to warn and that the omission to do so would constitute negligence. This, he argued, is because giving a warning would constitute 'proper medical practice'.[190] This is because, according to this judgement, any warnings given are governed by medical criteria.[191] Hence, medical evidence is of crucial importance and determines the issue.

Still considering the hypothetical argument according to which Lord Caplan was incorrect on the pivotal point of the pursuer's hypersensitivity, he went on to consider causation: this is as subjective a test as is that in England. His Lordship concluded that Mrs Moyes would have succeeded with her action had she established a prior hypersensitivity to the contrast medium.

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[189] 1989 SLT 444.

[190] Ibid. 447. This indicated that the standard in *Bolam* and that in *Hunter v Hanley* are analogous, because Lord Caplan did not refer to *no* responsible medical practitioner making such an omission.

[191] Ibid. 449G-K, 450B-D, 450 F-L.

In *Gordon v Wilson*,[192] too, the court had to contend with the evidence of two opposing bodies of medical opinion. The pursuer had a benign tumour removed and sought damages for a failure to diagnose the tumour earlier. She alleged that the delay resulted in nerve damage. The court held that where there were two bodies of respectable medical opinion, each with an opposing view, negligence could not be found.[193] In this case the medical evidence had to establish the factual cause of injury and to give opinions on whether the competent general practitioner would have diagnosed the meningioma earlier, given the presentation of symptoms. Again, because the test used was that set out in *Bolam* and *Hunter v Hanley*,[194] as opposed to asking what the reasonable patient would expect, medical evidence was crucial in determining the standard of care.

Finally, that same test was used in *Goorkani v Tayside Health Board.*[195] On the medical evidence, the pursuer persuaded the court that the reasonable medical practitioner would have warned of the risk of sterility from taking a particular immunosuppressive drug for more than three months. This assessment was based on the established medical facts pertaining to the risk of sterility.[196] The medical evidence thus established factual causation. However, it also established that the pursuer would have gone blind without the drug; hence it was held that legal causation was not established because the pursuer would have accepted that risk had he known of its existence.[197] Clearly the test for legal causation is a subjective one and, hence, medical evidence constitutes a guide for the court which, when placed alongside the pursuer's own evidence and subjective circumstances, aids the making of a decision by the court.

Unlike the English position, we will see in the next chapter that a patient-based disclosure law north of the border is less likely, though still possible. This means that the conclusions one is able to draw on the basis of the 'erosion'[198] cases may be drawn in respect of Scots law on the basis of *Goorkani*. In addition, however, we will be able to draw certain

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[192] 1992 SLT 849.
[193] Ibid. 852F and 852L-C.
[194] As elaborated and commented on in *Whitehouse v Jordan*, *Sidaway* and *Moyes*, all of which were approved of in the present case.
[195] [1991] 3 Med LR 33.
[196] Ibid. 35, col. i.
[197] Ibid. 38, col. ii.
[198] Specifically, *Smith v Tunbridge Wells HA*, *Newell and Newell v Goldenberg*, *McAllister v Lewisham* and *Goorkani v Tayside Health Board*.

comparisons, based on the law of delict, with the position as it is in South Africa.

5.5. CONCLUSIONS: THE DELICT / TORT MATRIX

The state of the law in each jurisdiction has been discussed. By way of summary it will be constructive to consider those facets of the judicial inquiry in which – relative to each particular jurisdiction – the expert will be most important. For example, in Britain the expert is more useful in respect of findings on the standard of care than he is in Canada and Australia. In the causation inquiry, however, the expert is useful in respect of factual rather than legal causation in all jurisdictions covered.

5.5.1. DUTY AND FAULT

The evidence of medical experts is at its most influential at this point in Britain. Because of the tests in *Bolam* and in *Hunter v Hanley*, as elaborated by the case law already discussed, the expert will speak to the fault element of the standard of care in the law of torts or delict. Because of the elevated importance of medical evidence at this point, the exchange of evidence between the two sides will also have an enhanced importance. [199] In Australia and Canada, on the other hand, the test is one taken from the point of view of the patient and the medical evidence is useful to the court merely to inform court and jury of the medical facts. In South Africa, the use of the *volenti* defence means that the doctor will have complied with the standard of care by the fact of having told the patient of the attendant material risk. Medical evidence in the form of notes will be useful in this.

5.5.2. MATERIALITY REVISITED

Materiality is the term linking the standard of care to legal causation. Whether 'material risk' is defined from the point of view of the patient or the medical practitioner will determine the weight given to medical evidence at that point of the inquiry. In Britain materiality is construed from the point of view of the reasonable medical practitioner and evidence of the likely actions of members of the profession; consequently medical evidence *per se* carries more weight than it does elsewhere. Materiality is assessed by an expert: that is, was it, in the opinion of the expert,

a material risk - as judicially defined - and ought there to have been warning thereof - as medically defined. This demonstrates the discursive clash between law and medicine more than it does in Canada and Australia where a patient-centric test for materiality ensures that medical evidence carries less weight than the evidence of the patient and, of course, the court's assessment of that evidence.

5.5.3. INJURY

The presence of injury is a question of medical fact. Whatever the common law jurisdiction, medical evidence will be brought (and exchanged between the parties) substantiating the applicable fact.[200] It will also be pertinent to an assessment of quantum should special damages be held to run to loss of earnings and should general damages be held to include *solatium.* Other heads of damages will require expert evidence not only from medical professionals but from actuaries and members of other professions. Such heads include loss of expectation of life, impairment of functions and fitness for employment. In such instances, medical evidence relating to diagnosis and prognosis will be used alongside the evidence of other professionals to arrive at a compensation figure.[201] This is no different to the procedure which follows ordinary negligence cases.

5.5.4. CAUSATION

In disclosure cases the plaintiff or pursuer will allege that the omission to inform of a material risk inherent in the procedure caused the injury.[202] Factual causation is a question of fact. However, disclosure cases are simpler than cases of negligence *simpliciter* such as *Wilsher v Essex* in which multiple possible causes were argued in court. Disclosure cases, on the other hand, are binary matters: either the information was present or it was not. In the absence of information on the material risk, the court would ask if it was the procedure connected to the risk which resulted in the injury complained of. The court will then ask whether knowledge of that risk would have made a difference to the plaintiff.[203] In all jurisdictions under discussion,

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[199] See Powers & Harris ibid. 11.87 et seq.
[200] See David M. Walker. Ibid. 403-404.
[201] Though it must be borne in mind that levels of general damages are guided by precedent.
[202] See Powers & Harris. Ibid. 1.80. et seq. This has already been covered in Chapter 4.
[203] Cf. Nelson-Jones & Burton. Ibid. 67-74.

courts use a test in which lay evidence is more important than medical evidence. However, as decisions such as *Newell and Newell v Goldenberg* indicate, the court will often have to use medical evidence in order to test the plaintiff's assertions that with the information that was lacking, they would have refused the medical procedure which factually caused injury or would have taken steps to minimise the effects of that risk or the chance of it occurring.

5.5.5. JUDICIAL POLICY AND RISK MANAGEMENT

Policy has been formed; now it has been shown how the courts use expert evidence to apply that policy by using it to different degrees at different points in the judicial inquiry. This means that a jurisdiction which has adopted a patient-centric policy, will use expert medical evidence less where the patient has something to contribute. However, it is interesting to see just how the courts will use medical evidence and what weight is given to that evidence. This is itself evidence of the extent to which a given jurisdiction adopts a policy which speaks to the interpretation of evidence in a way which favours patient or practitioner. *Bolam* is a rule of evidence which favours members of the medical profession. It is hence understandable that adherence to that standard will marginalise the importance of lay evidence in the inquiry into the standard of care. It is equally understandable that medical evidence will be marginalised where the *Bolam* test has been dispensed with.

Legal causation, on the other hand, is a point at which all jurisdictions are more or less in accord. More subjectivity is injected into the judicial inquiry because the test is essentially about what the plaintiff would have done in the presence of the information. This can be gleaned only from the patient. However, should that evidence lack credibility, the court will have to test that evidence objectively. At that point medical evidence can be useful to the court. This is because of the hypothetical nature of this part of the inquiry.

This difference and the tendency of British courts to favour the medical profession tends to lend weight to the argument that British jurisdictions are holding on to the *Bolam* test precisely *because of* the subjective test for causation. By preventing the use of lay evidence which would allow the case to progress to an inherently subjective test for causation, the court is able to ensure that the system remains favourable to the medical profession. The advantage of this approach is the establishment of a benchmark practice in the form of current practices of the

medical profession, such that all courts would come to the same conclusion given the same set of facts. This power is entrenched by the fact that the judiciary has discretion to accept or reject expert testimony on the grounds of credibility and cogency, and so to remain the final, even sole, arbiter.

CHAPTER 6

INFORMED CONSENT: *QUO VADIS?*

6.1. INTRODUCTION

This chapter will discuss the future of informed consent in Britain. If one considers some of the extents to which the doctrine has been taken in some American jurisdictions, one can see the possible extents to which the doctrine may be taken if it were to be adopted in Britain. These American extremes may serve as cautionary tales for British jurisdictions and may constitute judicial reasons *not* to adopt the doctrine of informed consent, because it has been applied to information about the physician rather than the medical procedure. This, in turn, will constitute the slippery slope.

If these cases do serve as cautionary tales, one might want to consider possible routes towards British adoption of the principles underlying the doctrine of informed consent. These principles are based on 'the patient's right to know'[1] which itself presumes the doctor's duty to tell. This chapter will therefore consider judicial trends in America as well as both judicial and medical trends in Britain. These medical trends are important because of the courts' reliance on the *Bolam* test.

The *Bolam* test is a test through which the judiciary sanctions responsible medical practice, even although it retains the power to declare such practices unreasonable. It was argued in Chapter 4 that the *Bolam* test may be eroded in the courts in respect of the standards of disclosure of inherent risks. In *Sidaway,* it was held that the *Bolam* standard should also be applied to disclosure cases,[2] with the court remaining the arbiter. The court may, however, find the evidence of a responsible body of medical witnesses to be unreasonable. It is at that point that there is scope for the introduction of a disclosure standard based on patients' rights because the judiciary allows itself to declare certain practices unreasonable even if supported by a responsible body of medical opinion. In *Newell and Newell v Goldenberg*,[3] for example, the court found that the body of experts that would not have given a warning of the chance that a

[1] See Sheila A.M. McLean. *A Patient's Right to Know.* 1989. Dartmouth. Aldershot.
[2] [1984] QB 493, 511 *et seq.*, [1984] 1 All ER 1018, 1026 *et seq.*

vasectomy might reverse itself, was neither reasonable nor responsible. And the House of Lords judgement in *Bolitho v City and Hackney Health Authority*[4] serves as authority for the fact that there may be circumstances in which expert evidence is not to be relied upon.

In disclosure cases there is more room for debate on whether the information actually given was adequate for the individual patient than there is room for debate in ordinary negligence cases as to whether due care was exercised responsibly. This is because it is easier for a judge to assess the patient's information needs and expectations, relative to the doctor's duty, than it is to assess whether due skill and care was exercised by the doctor or surgeon.[5] That this is the case is evident from the argument presented in chapter 4.

The crux of the informed consent issue is how much information is required and who decides upon that amount.[6] In *Sidaway* Lord Bridge noted that the 'Judge might come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonable prudent medical man would fail to make it.'[7] This made it clear that the court is the arbiter on the standard of care.

Thereafter, it becomes a question of which factors are to be taken into account by the court and of how much weight is to be given to each factor. These factors include what this plaintiff may have done had she had the information which was lacking, what the reasonably competent practitioner would have disclosed and what the reasonable patient would have expected by way of disclosure. Much of this has to do with materiality and the perspective from which materiality is assessed.[8] It also has to do with assessment on the basis of hindsight, and it is at this point that the House of Lords' Judgement in *Bolitho* is important because, as in disclosure cases, it had to do with hypothetical legal causation and with the authority of expert evidence.

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[3] [1994] 5 Med LR 343.
[4] [1997] 4 All ER 771.
[5] Cf. Chapter 5 on the points in the judgement at which the expert witness is useful to the court.
[6] Gee D J & Mason J K *The Courts and The Doctor.* 1990. Oxford University Press. Oxford. 172.
[7] *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643 (HL), 663.
[8] Cf. 3.3.

6.2. SOME AMERICAN EXTREMES

It is at the point of *materiality* that the doctrine has been expanded in some American jurisdictions and adopted to varying degrees in parts of the Commonwealth. This expansion has occurred in the 'positive' and in the 'negative' sense. In the positive sense, the judicial application of the doctrine has expanded to require the provision of even more information, in particular information about the physician as well as the risks inherent in the treatment. In the negative sense, the doctrine has expanded to found liability for the disclosure of too much information.

It is one thing to say that the requirements of informed consent have been expanding in favour of a more comprehensive disclosure, but another to be able to say just how far this obligation has extended, or indeed may extend in the future. Courts have held that it is not reasonable to require disclosure of all information available to the practitioner; but a liability in tort for excessive disclosure is emerging, suggesting the need for a cap on the requirement of information-supply.

'Over-information' would in the law of torts or delict have to cause physical or psychological harm to be actionable. This points to a potential conflict between the duty to inform and the duty of care. Van Oosten considered the doctrine of informed consent as applied to liability for 'over-information'. He argued that although in English and South African law this liability does not [yet] exist,[9] on the basis of existing judicial statements it would appear that the law in those two countries could follow that of Germany.[10] He drew on a statement by Watermeyer J in *Richter v Estate Hammann*[11] that 'it may sometimes even be advisable for a medical man to keep secret from his patient the form of the treatment he is giving him.' In *Sidaway*, Lord Templeman showed this possible slippage towards acknowledging liability for excessive disclosure when he stated that,

> 'A patient may make an unbalanced judgement because he is deprived of adequate information. A patient may also make an unbalanced judgement if he is provided with

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[9] Or did not exist at the time van Oosten was writing.

[10] FFW van Oosten 'The Doctor's Duty of Disclosure and Excessive Information Liability.' (1992) 11 *Medicine and Law* 633 - 639. That duty now exists in South Africa following the Appeal judgement of the Supreme Court in *Castell v DeGreef* 1994 (4) SA 408.

[11] (1976) 3 SA 226 (c) 232. van Oosten ibid. 634. This is a similar form of argument to that which will later be used to argue for an erosion of the *Bolam* principle in England and Scotland with regard to disclosure and informed consent in negligence cases. Cf. 6.3.2.

> too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality. Thus the provision of too much information may prejudice the attainment of the objective of restoring the patient's health.'[12]

Even although it is possible to argue that telling the patient too much about the medical procedure in question, caused psychological harm, the defence of therapeutic privilege would remain available. It is considered, however, that this area of law falls outwith the remit of this thesis because informed consent is about omission liability – liability for *omitting* to divulge certain material information.

Any research into this area of law would require the researcher to consider omissions to divulge material information which, had it been disclosed, would have resulted in a decision on the part of the patient against the proposed treatment. What one would be looking for is an extreme born of the doctrine which would give rise to judicial arguments involving a slippery slope as justification for not taking on board the legal doctrine in question.

6.2.1. IMPLICATIONS OF AMERICAN EXPANSION FOR OTHER JURISDICTIONS

Slippery slope arguments can be defined as a combination of rule utilitarian ethics with an empirical claim about the action's effect on inhibitions.[13] Applied to the present situation, this suggests that were the doctrine of informed consent to be adopted in the United Kingdom, there would be a flood of such claims, and that these claims may be about information on the surgeon rather than the medical condition. The question is, if other jurisdictions adopt the doctrine, do they take on board all of its developments in America as *fait accompli*? At the very least, it could be argued that any expansion of the *application* of the doctrine, would serve as a warning to any jurisdiction contemplating its adoption. For this reason, one would want to ask where the doctrine has led other jurisdictions; that will make it possible to put any such progression forward as a reason against adopting the doctrine. For example, how much information *about the physician* may be required? Given that, according to the doctrine, a patient is entitled to information on all material risks inherent in a prospective procedure, recent developments have

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[12] [1985] AC 871, 904.

[13] The combination goes back to the beginnings of utilitarianism in which Jeremy Bentham argued against infanticide although he thought that killing newborns harmless in itself, since newborns allegedly did not

begun to require the communication of information about the physician.

This happened in *Hidding v Williams.*[14] The case demonstrated the need to draw a line between the patient's right to know and the physician's right to privacy.[15] *Hidding* was an informed consent case which *also* concerned alcohol abuse by a surgeon. It was established that there had been violation of the informed consent doctrine through the physician's failure to advise of significant material risks of the surgery which would have influenced the injured patient's decision to undergo that surgery.

Having resolved the case on that ground, Gothard J went on somewhat unnecessarily to discuss Dr Williams' failure to disclose his chronic alcohol abuse. He held that issue to be 'of equal if not more importance' and said,

> 'because this condition creates a material risk associated with the surgeon's ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment, the fact finder's conclusion that non-disclosure is a violation of the informed consent doctrine is entirely correct.'[16]

It was held that failure to disclose this abuse, vitiated the patient's consent even although there was no evidence that the care itself fell below established standards.[17] Nonetheless, it was held that his condition created a material risk, assessed relative to a patient-centric standard, associated with his ability to perform. The issue forms very much part of the judgement because Gothard J said that it breached the informed consent *doctrine.* This is a dangerous precedent to have set because in future cases it could be taken to apply *only* to the information on the physician's health. It is argued that precedent in Britain and the Commonwealth would, on the basis of prudence and policy, decline to follow this sort of decision.

Moreover, the reasoning of the court falters when it tackles factual causation because alcoholism may not *always* impair performance. In tort the patient would have to establish a

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suffer. But he warned that such acts would lessen the inhibition against killing others, and thus should be prohibited.

[14] 578 So 2d 1192 (La App 1991).

[15] Ralph Slovenko. 'Informed Consent: Information about the Physician.' (1994) 13 *Medicine and Law* 467-472, 469.

[16] 1196.

[17] Slovenko. Ibid. 478.

causal link between lack of information and the injury suffered. The question is open as to whether is it sufficient to argue that but for lacking the piece of information about the doctor in question, the subjective patient would not have had surgery at all. In *Hidding* Judge Grisbaum argued that,

> ' ... the gut question posed is simply this: whether a professed and practising alcoholic can operate on any patient without breaching his standard of care. In other words, if there is a resulting injury and the doctor performing the operation is a practising alcoholic and this alcoholism is not disclosed to the patient prior to the surgery, do we have liability? Given this factual scenario and considering the record in its entirety, I say, "Yes." Ergo, this question must be viewed on a case-by-case basis.'[18]

However, it is not possible to establish causation between the lack of information and the injury, especially if the injury is a built-in hazard, without passing the objective,[19] *but for* test. It is argued here that this is an insufficient causal connection to establish tort liability in Britain, because informed consent has not been adopted as a doctrine descriptive of the standard of care. Given an injury during surgery in which the surgeon was *not* at the time under the influence of alcohol, in order to establish liability the plaintiff would have to that there was a duty to warn of that alcoholism *and* that the injury suffered was due to that omission. This set of facts takes the doctrine further than the informed consent scenario sketched at the beginning of this thesis.

It is also a basis for the argument that in disclosure cases in some American jurisdictions, the focus is more specifically on legal and hypothetical causation, through the definition of materiality. This is a point at which the doctrine may be expanded further, because with emphasis resting so much on the 'but for' test, the factual relationship between the omission and the surgery becomes increasingly tenuous. For example, would it be possible to sue under the doctrine of informed consent following competent surgery which failed to achieve its desired result on the ground that but for lacking information to do with the surgeon, the patient would not have had surgery at all? It seems that following *Hidding* the answer is that it would. As regards the doctrine of informed consent and according to *Hidding*, if knowledge of the surgeon's alcoholism is held to be material, there need not be an injury necessarily factually connected with alcoholism, for liability to follow. This is because liability would be based on the doctrine of informed consent rather than on negligence *simpliciter*.

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[18] 578 So 2d 1192 (La App 1991). A page citation is not available because this case was sourced from LEXIS.
[19] However, consider 4.2. on the various American States' tests for causation.

Because *Hidding* has been used as an example of a possible extension of the doctrine and because that case also involved informed consent as this thesis has hitherto understood it, the next question which needs to be posed has to do with the prevalence of cases and which have to do with information on the physician as founding liability under the doctrine of informed consent. That will speak to the degree of caution to be taken by British jurisdictions.

So-called 'physician-specific disclosure' has recently been recognised as a problem.[20] It has been argued that the doctrine 'obliges physicians to share the decision-making process with patients.'[21] It is a short step to include in that process any information which could affect the patient's decision on treatment. The extension here is an extension of the rule in *Canterbury* that a doctor's duty is to give adequate information regarding the proposed treatment.[22] Applying an objective patient-centric disclosure standard, the matter of materiality is in the hands of the reasonable patient. From there it is a short step to require physician-specific disclosure on the ground that the reasonable patient would expect it.

Such disclosure has taken several forms which have been grouped under the heading, the 'self-interest of the physician'.[23] These interests can be related to the physician's economic interests or indeed health interests such as those relating to substance abuse or indeed HIV status. This will speak to the fiduciary nature of the doctor-patient relationship which itself forms the basis of liability under informed consent, because the fiduciary relationship requires raised standards based on good faith in the context of a disparity in individual power.

Heineman cites several examples which are worth noting here for the sake of completeness.[24] In respect of economic interests, it was held in *Moore v Regents of the University of California*,[25] that the surgeon's profit from the patient's spleen tissue clouded his judgement, so creating a duty of disclosure when seeking the patient's informed consent. The interest of the case is this: because the splenectomy generated financial benefit rather than

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[20] See, for example, Heineman, Richard A. 'Pushing the limits of Informed Consent: *Johnson v. Kokemoor* and Physician-Specific Disclosure.' (1997) *Wisconsin Law Review* 1079.
[21] Ibid. 1081.
[22] *Canterbury v Spence* 464 F.2d 772, 783.
[23] Heineman. Ibid. 1089 et seq.
[24] Ibid. 1091 et seq.

physical injury, the court concentrated on the context of the doctor-patient relationship. But because it did not do so overtly, the door was left open to broaden the parameters of required disclosure. This door is open to requiring the inclusion of any information based on a conflict of interests born of the desire to conceal personal information. As has been argued, this information has been held to apply to the physician's medical circumstances; but it may also apply to his personal failings.

In 1996 the Wisconsin Supreme Court handed down its judgement in *Johnson v Kokemoor.*[26] The case concerned several issues such as the use of comparative risk data and the obligation of referral to a tertiary care centre, but of interest here is information on the physician's track record. Surgery to clip an aneurysm was a technical success, but still left Ms Johnson disabled. The plaintiff alleged that Dr Kokemoor 'overstated the need for surgery and exaggerated his level of experience in performing the type of surgery he proposed.'[27] Again this was a matter of communication in the consultation. Whereas the defendant had performed that type of surgery only twice, the plaintiff alleged he had said he had done so 'several' times. In addition he allegedly failed to inform her that he was not 'board-certified' in neurosurgery and that he was not a sub-specialist in aneurysm surgery. Again, the case also concerned information on the risk which actually caused the injury suffered, but that did not stop the court ruling on the information specific to the physician. It was, in fact, the issue which occupied the appeal to the Supreme Court of Wisconsin and can hence be seen as a cautionary tale in itself, because the issue before the court had to do with the admissibility in evidence of the surgeon's experience.

On that issue, the court found that information on the surgeon's relative inexperience was material on the ground that disclosure standards are set by the reasonable patient. However, as Heineman argued, the decision was not explicit about the fiduciary basis of its finding.[28] This means that a breach of trust becomes represented as negligence under the doctrine of informed consent. This occurs through the use of the definition of materiality. As Heineman put it, 'The court's analysis also blurred issues of decision and injury causation.'[29]

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[25] 793P. 2d 479 (Cal. 1990).
[26] 199 Wis. 2d 615, 545 N.W.2d 495 (1996).
[27] Heineman. 1100.
[28] Ibid. 1103.
[29] Ibid.

This is a point which was made earlier in the current chapter. Perhaps more importantly, 'the decision potentially subjects physicians to liability for non-negligent suboptimal care – notwithstanding the difficulty of determining whether additional experience would have made a difference.'[30]

What is clear from these cases is that the doctrine of informed consent in tort law is now being used to found liability for failure to disclose information on the physician's health and surgical experience. This began with the adoption of a patient-centric definition of materiality. Therein lies the cautionary tale and indeed the constitution of the slippery slope.

From this, one can argue that were British jurisdictions to adopt the doctrine, that is where that slippery slope could lead us. Even if British courts were to adopt the doctrine, it is arguable that the difference between private and public health care would play a part in the extremes to which the doctrine could be taken in the United Kingdom. It is argued that because health care in Britain is largely a public service, it is extremely unlikely that courts would compel disclosure of the surgeon's track record because that would be antithetical to the ethos of the National Health Service itself. However, because British jurisdictions have not adopted the doctrine of informed consent, and with it a test which defines materiality relative to the patient's values, cases analogous to those discussed above, would at most amount to the loss of the indication to engage a different surgeon if desired.

6.2.2. CAUSATION AND LOSS OF CHANCE

The question has been alluded to: is there something in the loss of chance doctrine which will be useful to the plaintiff in the case of an alcoholic surgeon, or indeed in the case of the surgeon who is HIV positive, as occurred in *Faya v Almaraz* in Louisiana?[31] For example, loss of the chance to engage a surgeon who is not HIV positive, has a better track record or is not an alcoholic. In *Faya*, the court upheld an appeal to hold that the distress and anxiety caused by the knowledge that the surgeon was HIV positive and could therefore have infected the appellant, imposed a duty based on the doctrine of informed consent, to disclose that information to the patient.

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[30] Ibid.

If the informed consent doctrine is being gradually accepted across the Commonwealth and its current status in America[32] extends to that outlined in *Hidding v Williams* and *Faya v Almaraz*, is it not possible that the loss of chance doctrine could be used to support proof of causation? If an argument based on the loss of a chance were put forward, it would be presented in argument on mitigation of damages rather than for the liability issue itself.[33] The loss of chance in *Hidding* and *Faya* was the chance to engage an alternative physician.

A parallel can be found in *Kay's Tutor v Ayrshire and Arran Health Board.*[34] It was held that it was necessary to prove an actual increased risk of harm due to negligence before the *McGhee* principle would apply.[35] If the act of the defender materially increased the risk of harm then this may establish causation. In *McGhee* it was held that failure to provide washing facilities materially increased the risk of dermatitis and this was sufficient to found liability. It is recognised that *McGhee* was not a 'loss of chance' case, but a case involving the question of material contribution establishing legal causation. This was discussed in 4.3. In the present context, the question would *also* be one of causation which would ask, 'but for the loss of the opportunity to engage an alternative doctor, would this patient have suffered the injury which he in fact suffered?' In *Hotson v East Berkshire Health Authority*[36] it was considered that there was a greater than even chance that the injury was inevitable and so on balance of probabilities material contribution was not established.

In *Hotson* Lord Mackay said that he considered it 'unwise in the present case to lay down the rule that a plaintiff could never succeed by proving loss of a chance in a medical

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[31] 620 A 2d 327 (Md 1993).

[32] In Louisiana at any rate.

[33] Although argued at the point of damages and so not directly applicable to the causation inquiry, in *Wilsher v Essex Health Authority* [1988] 1 All ER 871, because there were four possible causes of the actual harm suffered damages were awarded at a quarter of the sum initially awarded. As regards disclosure cases, consider *Goorkani v Tayside Health Board* 1991 SLT 94 (in the present chapter as well as 5.4.4.2.) in which the pursuer failed to prove causation (and hence failed on the merits) yet was awarded £3,000 for the loss of the chance to become accustomed to his pending sterility; this indicates that the matter was not simply a question of quantum, but merits too.

[34] 1987 SLT 577.

[35] *McGhee v National Coal Board* 1973 SLT 14, [1973] 1 WLR 1: the Scottish case in which the material increase in risk test was established. This case concerned contracting dermatitis while working at a brick factory.

[36] [1987] 2 All ER 909 on loss of chance being an issue of causation or of damages.

negligence case.'[37] In the instance of an alcoholic surgeon, the possibility is open to a plaintiff to argue that not being informed that this surgeon was an alcoholic - and so engaging him on the basis of lacking that information - materially increased the risk of harm by depriving this patient of the chance to engage another surgeon.

Lord Mackay went on to say, 'your Lordships cannot affirm the proposition that in no circumstances can evidence of loss of a chance resulting from the breach of a duty of care found a successful claim of damages ...'.[38] It seems possible that the loss of chance doctrine could found actions in negligence. Yet in *Hotson* the question was one of competence in diagnosis which caused the loss of chance. To make the parallel fit alcoholism, the plaintiff would still have to prove that alcohol contributed to the injury suffered.[39] This is a question of fact. To make the scenario fit disclosure cases in Britain, courts would need first to adopt a test for materiality which is favourable to the patient. This, it is argued, is unlikely. Also unlikely is the court's adoption of loss of chance in medical negligence cases as precedent swings the other way. However, given the 'erosions' of the *Bolam* test considered in the last chapter, as well as the 'emergence of the patient's voice', are we not at the top of the slippery slope?

6.2. EMERGENCE OF THE PATIENT'S VOICE IN BRITAIN

The last chapter considered the emergence of the patient's voice in respect of those cases which were won by plaintiffs in England, through a causation test which is similar to that employed by the Canadian judiciary.[40] The common law is able to take on board academic writings, case law in other analogous jurisdictions and other legal and *quasi* legal documents such as conventions on human rights and patients' charters. Such writings will influence the medical fraternity insofar as greater recognition is given to the views and needs of the patient; they influence the judiciary in the same way. They also influence the patient insofar as he may become educated in respect of these rights, and seek to assert them.

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[37] [1987] 2 All ER 909, 916.

[38] Ibid.

[39] Unless one could argue that one had suffered nervous shock as a result of learning that one's surgeon was HIV positive. This, however, would not be on the basis of the doctrine of informed consent and would require a traumatic event. The law in the United Kingdom would probably not consider that the post-operative telling of a patient that that patient's surgeon was HIV positive, constituted such a traumatic event. That this is the case and that forseeability and remoteness are the tests used is evident from *King v Phillips* [1953] 1 QB 429, *McLoughlin v O'Brian* [1982] 2 WLR 982 and *Vernon v Bosely* [1997] 1 All ER 577.

[40] Cf. 5.4.4.

Judicial views, however, are influenced *by* the views of the medical profession because of the *Bolam* test. This is because the test is a floating benchmark for the courts. Therefore, as the medical profession recognises the patient's voice to a greater degree, this will become the standard by which members of the medical profession are judged. In terms of the legal tests for the standard of care, it is foreseeable that the standards of disclosure expected of the reasonable medical practitioner will become increasingly weighted in favour of more comprehensive disclosure.[41] This is based on patients' rights. It will be necessary, therefore, also to consider the views of the medical profession on the doctrine of informed consent.

6.3.1. A RIGHTS BASIS FOR CONSENT

McLean has argued that disclosure standards are non-technical matters and, as such, the courts' assessment of the appropriate standards ought to be made with reference to certain claimed interests.[42] On this basis it may be argued that where there is an interest in a particular piece of (material) information, there may also be a right to receive that information. This right would exist in law where courts hold that there is a duty to provide the information. The central issue is whether the patient feels that he or she has the right to that information and whether the courts can in due course consider that right worthy of legal protection. This is a moral point, rather than merely a matter of professional practice.

Judges in *Castell v DeGreef, Rogers v Whitaker* and *Reibl v Hughes* all invoked patients' rights as the rationale for adopting a more patient oriented consent doctrine, as did Lord Scarman in *Sidaway*. In none of these decisions was any document such as a bill of rights invoked even although that might have been an option; such rights are deemed to exist *sui generis* and are not dependent on positive law.

In Britain there are several documents to which argument might have recourse. The European Convention on Human Rights and Biomedicine will be discussed shortly.[43] In addition, the National Health Service Patients' Charter of 1992 states that every citizen has the

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[41] Consider, however, Mason & McCall Smith, *Law and Medical Ethics* (4th Edition), 247, in which it is indicated that such a process is already under way.
[42] McLean. Ibid. 83.

right 'to be given a clear explanation of any treatment proposed, including *any* risks and alternatives.'[44] The most recent Department of Health Patients' Charter is more explicit.[45] This right has gained recognition by the medical profession. It may also exist as part of the duty of care by virtue of that recognition in the context of the *Bolam* test.

6.3.1.1. A CRITIQUE OF LORD SCARMAN'S ARGUMENT IN *SIDAWAY*

Lord Scarman argued that the doctor's duty stems from his patient's right. This is to be welcomed, yet such a rights-based approach obscures the logic of tort law and the duty of care. His Lordship seemed to assume instead that the right existed *sui generis* and *gave rise to* the doctor's duty.

However, in the law of torts the duty of the medical practitioner stems from the law of torts itself and the duty of care. It is correct to argue that a duty presupposes a right, but the slippage made by Lord Scarman comprised trying to establish a causal connection between right and duty. Yet the relationship between duty and right is symbiotic rather than causal and the beginning point of that relationship is the judicial definition of the standard of care within the professional duty.

Any argument will begin with the existing definitions and tests in the duty of care. One facet of that standard is the right-of-the-patient-and-the-duty-of-the-practitioner as a single indivisible unit. Yet this does not mean that the right to information *may not* be constituted by a positive right which itself presupposes a duty. At the time of Lord Scarman's judgement, no such positive expression existed. This is no longer the case – which is perhaps a testament to Lord Scarman's foresight.

6.3.1.2. THE EUROPEAN CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE

The *Convention* was opened for signature on 4 April 1997. Although the United Kingdom has not yet taken up that invitation, it remains another arrow in the quiver of patient

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[43] In 6.3.1.2.

[44] *The Patients' Charter* 1992, 9; own emphasis.

autonomy. Article 5 states the general rule that 'an intervention in the health field may only be carried out after the person concerned has given free and informed consent to it' and that '[t]his person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.' There is not, however, any indication as to what test will be used to establish whether information is 'adequate' or not.

It is argued that the *European Convention on Human Rights and Biomedicine* will be influential in British adoption of consent principles based on the doctrine of informed consent. The Convention is open for signature by, *inter alia*, Australia, Canada and the USA as non-member states which 'have participated in its elaboration ...'.[46] Considering that informed consent is a doctrine of American construction and Canadian and Australian elaboration, it is likely that what delegates had in mind during the process of formulating Article 5 was the doctrine as articulated in their own jurisdictions.

The use of the words 'informed' and 'consent' together suggests to common law jurisdictions that it is the *doctrine* that is being invoked. To non-common law jurisdictions, no such invocation need be suggested. Indeed, in the Spanish version of the Convention, the word 'informed' does not appear next to 'consent' because to consent without information is deemed conceptually impossible.[47] As in the French version, the Spanish version of the Convention stipulates that the patient must give consent after having been informed, but this does not include the juridical concept of *informed consent*. However, because England and Scotland are common law jurisdictions, we must consider the possibility that it is the doctrine which is being considered in the use of the term 'informed consent' by the Council of Europe.

Paragraph 35 gives some indication of the meaning of 'informed consent'. This reflects only the opinion of the Steering Committee and does not constitute a binding instrument. Aside from the *Explanatory Report* to the Convention, there is no publication setting out the rationale of each clause and the preparatory work of Steering Committee remains

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[45] http://www.open.gov.uk/doh/pcharter/patientc.htm.

[46] See 33(1); these countries had observer status within the Steering Committee of Bioethics.

[47] For this information I am sincerely grateful for the comments of and fruitful discussion with Dr J. Corbella Duch of the Fundació de Gestió Santària de L'Hospital de la Santa Crei sant Pau, Hospital Universitari de la Uab, Barcelona.

classified and restricted.[48] However, because the Convention does not constitute a binding instrument, the term 'informed consent' would need to be interpreted according to national law. That said, it remains possible to speculate on the future of informed consent principles in Britain on the basis of the argument that the common law is influenced by academic writings, the existing body of case law as well as other national and international codes.

6.3.1.3. BRITISH INCORPORATION OF HUMAN RIGHTS

While the UK Government has not incorporated all of the European Convention on Human Rights into domestic law,[49] the Human Rights Act 1998 received Royal Assent on 9 November 1998. This will come into force early in 2000, once there has been an extensive education programme for the judiciary.[50] The Human Rights Act 1998 does not set up a court dedicated to the adjudication of cases under its provisions, though it does oblige all courts to adjudicate matters consistently with the Act.

Of present importance, it does not incorporate the European Convention on Human Rights and Biomedicine. However, because the United Kingdom now has a Human Rights Act akin to the European Convention on Human Rights, it would appear probable that the UK could ratify and possibly incorporate the Convention on Human Rights and Biomedicine. Arguments might also be made concerning the European Communities Act 1972, which provides that in the event of conflict, community law prevails over domestic law. Future disclosure cases will be dealt with in the United Kingdom under domestic law and in the existing courts, but will be heard in the context of a court system which adjudicates matters relative to human rights.

What is evident is a trend towards the acknowledgement of human rights in the United Kingdom. One such right has been argued to be that of information in the context of medical

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[48] Correspondence by the present author with the Directorate of Legal Affairs at the Council of Europe has confirmed the observer status of these three countries and the fact that their delegates took part in the elaboration of the convention. This correspondence has also indicated that 'informed consent' will probably be interpreted according to national law as the Convention does not constitute a binding instrument. See Appendix B

[49] All of the substantive rights have been incorporated, but none of the procedural rights.

treatment. If the above argument on the meaning of informed consent in the Biomedicine Convention is accepted, the argument would make out a case for the adoption of the doctrine. This argument may be dependent on speculation about future parliamentary policy relative to the common law, but what does emerge, does so at the level of influence.

In practice terms, an analogy can be drawn with cases which went through domestic courts to Strasbourg. For example, *Campbell and Cosans v United Kingdom*[51] was won in Strasbourg by the plaintiffs. The influence of this and similar decisions on the British legislature was such that the law in Britain was amended to outlaw corporal punishment in schools. However, statutory change is an improbable route to the adoption of informed consent, because it is a judicial doctrine. To speculate on how the court would decide such a case, one should take into account the common law as reflexive, the influence of European law to which Britain is a signatory and the comparative nature of medical jurisprudence.

Should Britain ratify the Convention, it will become binding. However, it remains unclear what interpretation will be given to Article 5 on informed consent. This means that when considering developments in the law of the United Kingdom, it is necessary to continue to argue in terms of *influence*. Such influences include that of the European Convention on Human Rights and Biomedicine, of the law in America, Canada, Australia and South Africa as well as of existing trends within medicine as seen in the context of the *Bolam* test and the Patients' Charters. These influences, taken together, allow us to predict the arrival of an increasingly patient-centric standard in disclosure cases.

6.3.2. EROSIONS OF THE BOLAM STANDARD

It is argued that judicial resistance is to the wholesale doctrine rather than the consent principles it embodies, as well as to the slippery slope it threatens.[52] Yet in the years that have elapsed

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[50] See John Wadham & Helen Mountfield. *Blackstone's Guide to the Human Rights Act 1998*. Blackstone. London. 1999.

[51] (1982) 4 EHRR 293; corporal punishment in schools.

[52] This was stated more firmly by Lord Donaldson in *Re T (adult)(refusal of treatment)* [1992] 4 All ER 649, 663. Such a slippery slope means that once it is found that the duty of care included provision of information

since the *Sidaway* judgement was handed down, much positive critique has been given to the dissenting judgement of Lord Scarman. Indeed, not only have academics supported his approach, the British Medical Association has adopted it as an ideal mode of practice.

The *Bolam* standard is eroded by the assertiveness of the court over the weight of expert evidence. In this way it is eroded by using the *Bolam* test itself. A physician-based standard has been used to erode the *Bolam* test in informed consent cases by arguing that a physician's negligence is based on a responsible body of medical opinion.[53] The test itself remains more or less intact, but it is now able to support the plaintiff's case. This is because of judicial sovereignty over expert evidence.

This amounts to a *Bolam* standard being used to erode the *application* of the *Bolam* test in consent cases because *Bolam* is a rule of evidence. As current opinion fluctuates so standards are able to fluctuate to come in line with new developments in medicine. This has been argued to be the strength of the *Bolam* test, yet it means in effect that the *Bolam* test could be used to adopt the doctrine of informed consent, while perhaps not calling it by that name. Considering that there is a trend towards fuller disclosure in practice,[54] a professional standard assessed professionally makes for a particularly malleable legal test; it all boils down to the weight to be given to particular expert evidence. If there is a body of opinion available to the court, then it must be slotted in to the *Bolam* test and assessed in terms of reasonableness.

6.2.2.1. THE ENGLISH JUDICIAL EROSIONS

Having argued that the *Bolam* test, being a rule of evidence, may be eroded by the judiciary asserting its power over expert evidence, any argument made on the basis of the erosion of the *Bolam* test ought to begin with *Bolitho v City and Hackney Health Authority.* This is because that case had to do with those circumstances in which expert evidence is not to be relied upon as well as with the fact that it is a House of Lords judgement which had to do with omission liability in the medical negligence context.

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on the risk which eventuated, with a subjective test for causation already in place in tort law, the law would be set to become as patient-centric as that of Australia.

[53] This, of course, depends on the availability of a reasonable body of professional opinion. See Chapter 5 on the Expert witness, especially 5.3.

In *Bolitho*, the House of Lords held that a doctor could be liable in negligence despite the presence of a body of professional opinion which sanctions that doctor's conduct. The court found that in a minority of cases that body of professional opinion might not stand up to logical analysis. This involved overturning the judgement of the Court of Appeal which had held that the *Bolam* test required the court to accept that body of evidence. Lord Browne-Wilkinson held, 'the court is not bound to hold that a defendant doctor escapes liability for negligent diagnosis or treatment just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice.'[55] His Lordship went on to hold, 'It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.'[56] He went on to consider whether the case before him was 'one of those rare cases', to find that it was not.

Lord Browne-Wilkinson specifically stated that he was not 'considering questions of disclosure of risk.' It is argued, however, that this ruling will apply to disclosure cases because in *Sidaway* the House of Lords had held that the same standard is to be applied in both scenarios. If the same test is to be applied in both scenarios and the House of Lords in *Bolitho* elaborated upon how the test is properly to be used, then it should be the case that the *Bolitho* judgement will apply to disclosure cases, particularly because they are concerned with both omission liability and, by extension, hypothetical causation. There is some support for this in *Pearce v United Bristol Health care Trust*[57] in which Lord Woolf cited the *Bolitho* judgement with approval before going on to say,

> '... if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or he should adopt.'[58]

The Court of Appeal in this case was not only using a subjective test for causation, but was also building on the *Sidaway* judgement in which it had been held that a 'significant risk' was one in

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[54] Irwin, S., Fazan, C. & Allfrey, R. *Medical Negligence Litigation*. 1995. Legal Action Group. London. 22. Cf. 6.3.2.1.

[55] *Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All ER HL 771, 778d.

[56] Ibid. 779*j*.

[57] [1999] PIQR 53.

[58] Quote taken from LEXIS report.

the region of 10%. In the *Pearce* case, the risk of stillbirth caused by late delivery was estimated at 0.1 – 0.2% and was not, according to both the experts and Lord Woolf, significant. However, it remains the case that the term 'significant risk' is used in the same way as is the definition of 'materiality' in other jurisdictions. That, together with the above argument on the reading of *Bolitho* in conjunction with *Sidaway* and *Pearce*, indicates that a patient-centric test is on its way to the United Kingdom.

One can therefore reconsider those disclosure cases which indicated a similar trend in respect of the erosion of the *Bolam* test. 'Erosion' in this context means those judicial decisions which seemed to indicate that the solidity and sanctity of the *Bolam* test, as favourable to the patient, was in jeopardy.[59] In these cases the plaintiffs proved their cases precisely by using the *Bolam* test. Admittedly these decisions were been made by courts inferior to the House of Lords, yet it is significant that none of them have been appealed. When these cases are viewed alongside the above interpretation of *Bolitho*, it is possible to argue that the *Bolam* test will continue to be eroded. While they do not set any new precedent, they do indicate that the *Bolam* test is now useful to the plaintiff.

In *Smith v Tunbridge Wells Health Authority*,[60] the Queen's Bench applied the *Bolam* test in finding for the plaintiff. However, it is simplistic to argue that where the plaintiff won the case, *therefore* the *Bolam* standard has been eroded. Lord Diplock in *Sidaway* is cited as having said that 'we are concerned with volunteering unsought information about risks of the proposed treatment sought ...'.[61] The fact that the information is unsought at the time yet in hindsight is desirable leaves judicial hands relatively unfettered when it comes to determining what could reasonably be expected by the court of the surgeon rather than what is reasonably expected by the patient.

Following this case, Margaret Puxton QC commented that 'the major criticism of the *Bolam* test is that it gives too much weight to the opinion of doctors, in effect allowing the defendant's colleagues to usurp the function of the court in the determination of what amounts

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[59] These were discussed in 4.4.4. as *Smith v Tunbridge Wells HA*, *McAllister v Lewisham and Newell and Newell v Goldenberg*.
[60] [1994] 5 Med LR 334.
[61] *Sidaway*, 895D, *Smith v Tunbridge Wells HA*, 336.

to negligence.'[62] Yet courts continually assert their own competence over this expert evidence.[63] Puxton pointed out that the *Bolam* principle was covertly 'abandoned' by the court electing not to accept the expert evidence which said that a warning would not have been given.

In this case it was made clear that a court decides 'what the medical standards *should* be, not what they *were* at the time' which means that 'although he expressly rejected the argument based on ... *Rogers v Whitaker* he reached the same result by substituting the court's view of what was reasonable for the objective test.' [64] Although it may amount to the same thing, we are not simply talking about preferring patient or practitioner; we are talking about preferring the court's assessment of both, in terms of the legal test adopted. This appears to be evidence of a shift in judicial policy away from that adopted in the days of Lord Denning.

In *McAllister v Lewisham*, in asserting the court's power to assess negligence and reasonableness, Rougier J quoted a much-cited passage from the judgement of Lord Bridge in *Sidaway* in which his Lordship had said that 'the Judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.'[65] Similarly, in *Newell and Newell v Goldenberg*[66] Mantell J held that the body of medical opinion which would have withheld information was 'neither responsible nor respectable'; hence the omission was negligent. In other words, there was a body of medical opinion given, but the court said it was not respectable.

When it is argued that *Bolam* is used to erode *Bolam* and so to adopt principles broadly based on the doctrine of informed consent, what is meant is that the *Bolam* standard is used to assert negligence based on a judicial assessment of the reasonable medical practitioner. Again, this is because the *Bolam* test is a rule about the weight to be attached to the evidence given.

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[62] [1995] 4 Med LR 342. Lord Justice Sachs, quoted in *Hucks v Cole* [1993] 4 Med LR 393 as saying that ' ... in so far as the evidence shows the existence of a lacuna [in professional practice and] that lacuna was ... so unreasonable that as between doctor and patient it cannot be relied upon to excuse the former in an action for negligence.'

[63] Cf. the above argument on *Bolitho.*

[64] Puxton. Ibid. 342.

[65] *Sidaway*, 900E, *McAllister v Lewisham*, 351.

[66] [1995] 6 Med LR 371.

The argument here is about the *extent* of the duty of disclosure and the tests used to assess that extent. Only after that inquiry will the court go on to consider causation. In the law of torts or delict in Britain, this is a subjective inquiry, though in respect of disclosure cases it appears to be akin to the apparent-subjective test iterated in Canada insofar as courts try to exclude the element of hindsight. This in itself suggests a difference between judicial tests in respect of negligence *simpliciter* and negligence based on non-disclosure, though not at the level of the test for the standard of care; the difference becomes apparent in the causation inquiry.

It is contended that the cases discussed above herald the arrival of consent-based negligence which, as more similar cases are added, will lead to the inevitable conclusion that *a form of* the doctrine of informed consent is adopted by English courts.

From there it is reasonable to argue that with lack of informed consent being a basis for a finding of negligence, the *Bolam* test will be a tool to be used against surgeons rather than part of their own armoury.[67] This is because of the above argument, based on the House of Lords' judgement in *Bolitho*, that courts have started to make use of the sovereignty which they have so often asserted they have over expert evidence.

At present English courts assess 'materiality' relative to current medical practice. This means that as the medical profession acknowledges a greater need for patient autonomy, the courts will have to take the patient's point of view increasingly into account under the *Bolam* test; it is this adaptability to current practices which is often considered the strength of the test.

6.3.2.2. THE MEDICAL EROSIONS

As medical practice moves in the direction of more comprehensive disclosure in practice, certain non-disclosures will become unreasonable. It has already been stated that the British Medical Association puts forward the judgement of Lord Scarman in *Sidaway* as an ideal for practice. In addition, the medical profession tends to consider the doctrine of informed consent to be the law of the United Kingdom. That this is the case is evident from a series of articles in the *British*

[67] Considering these cases, it would appear that it is the judgement of Lord Templeman in *Sidaway* which is being used.

Medical Journal on the topic.[68] Many of these papers assume the term to refer to consent based on information. While this might be the case in medical practice, this thesis has argued throughout that in law the term refers to the *doctrine of* informed consent. However, it is apparent from any of these articles that authors consider the term to be self-evident. It is certainly the case in the UK that medical practitioners ought to inform their patients and gain their patients' consent. If the medical profession considers that the law requires an increasingly patient-centric disclosure standard, then with the *Bolam* test as an entrenched rule of evidence, that standard will become required in medical practice and in law.

The General Medical Council recently issued advice for doctors on seeking patients' consent in the form of a publication entitled *Seeking Patients' Consent: the Ethical Considerations.*[69] Of present interest is the fact that the Council notes that, 'Patients have the *right* to information about their condition and the treatment options available to them. The amount of information you give each patient will vary, according to factors such as the nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient's own wishes'[70] Doctors should, therefore, not make assumptions about patients' views but should ask whether they have any concerns about the treatment or the risks it may involve.[71] The publication also notes that implied consent does not imply understanding of the risks involved in the proposed treatment. This indicates that the GMC is advising a practice standard which is broadly similar to the patient-centric legal standard inherent in the doctrine of informed consent. In fact, that is the general tone of the document itself.

It has been argued that members of the medical profession do not have control over the outcome of medical negligence cases. The courts are willing to find practices unreasonable even if supported in evidence by responsible bodies of opinion. The *Bolitho* judgement and the 'erosion' cases support this. However, even if the practices of the medical profession continue to be a primary judicial consideration, it is clear that these practices themselves support the

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[68] See, for example, Len Doyal, J S Tobias, Mary Warnock, Lisa Power, and Heather Goodare in (1998) 316 *British Medical Journal* 1000-1005 and an editorial in that issue by Richard Smith: 'Informed consent: edging forwards' (and backwards).'(1998) 316 *British Medical Journal* 949-951.

[69] GMC Seeking Patients' Consent: the Ethical Considerations. 1999.

[70] Ibid. 3. Own emphasis.

[71] See Linda Beecham. 'GMC advises doctors on seeking consent.' (1999) 318 *British Medical Journal* 553.

doctrine of informed consent. If members of the medical profession do not have control of legal standards, but courts do, and if the courts are themselves looking increasingly to the evidence of the plaintiff in disclosure cases, then without tampering too much with *Bolam*, it is possible to adopt many of the principles of informed consent. This is because of what was argued earlier in the present chapter about patients' rights, their knowledge of these rights, their concomitant desire to take more control of their own medical treatment as well as because of the courts' and the medical profession's recognition of these factors.

6.3.2.3. INFORMED CONSENT, *QUO VADIS* ?

In the context of changing judicial and medical views and in the context of the influence of foreign judgements and European law, one might consider the very *threat* of such a case finding its way to Strasbourg. This would affect domestic law and it is arguable that domestic courts may on that basis decide in a plaintiff's favour in the informed consent scenario. But it will not do so at the expense of the *Bolam* test. Even if the court were to decide the matter according to domestic rather than European law, the timing of the case will be crucial because of ongoing changes within a medical profession whose praxis is held in such judicial esteem.

Given the trend towards more comprehensive information disclosure in medical practice alongside the 'erosion' cases and the reflexivity of the common law, it is argued that it may be expedient for domestic courts to preempt a decision in Strasbourg. While the doctrine of informed consent as articulated elsewhere is unlikely to be adopted *per se*, the principles it embodies are gradually becoming the standard by which medical practice is measured by British courts. This is possible because of the combination of judicial and medical factors and because the common law is inherently both flexible and comparative; within medical law this comparison is of a more international nature.

For the judiciary to remain protective of members of the medical profession, it would need to resist the doctrine yet allow consent principles to develop from within the profession. This will leave the *Bolam* test intact and, eventually, would favour the plaintiff. This judicial process would also remain a balanced one. However, even although it appears from the above

argument that the *Bolam* test is one which is able to support the plaintiff's case and is therefore able to protect patients' rights, one is still brought back to an underlying question which remains something of a monolith: is it appropriate and desirable that issues such as the adequacy of information disclosure be left in the hands of the medical profession, even although those hands are judicially scrutinised? Even if the *Bolam* test is now able to support the plaintiff's case, will it always be able to do so without the protection of a judicial test which assesses materiality from the patient's viewpoint?

It is noteworthy, however, that these 'erosion' cases were decided in English courts. With the current position in Scotland following *Hunter v Hanley*,[72] which pre-empted *Bolam* and has been likened to that test, it is reasonable to put forward the same arguments in respect of the Court of Session as were put forward in respect of the English courts. However, considering the use of the law of delict and the *volenti* defence as exemplified by the South African judiciary, the question arises as to whether Scotland has another possible route to informed consent.

6.4. SCOTLAND

The Scottish Court of Session in *Moyes* affirmed that a failure to warn of risks was always to be judged by practitioners' standards. What is needed in this context is a set of judicial criteria which has the approval of the medical community and which also takes patients' rights into account. This is possible north of the Border because the court in *Bolam* drew on *Hunter v Hanley* and the court in *Moyes* drew on *Sidaway*; we can therefore infer that what occurred in the erosion cases already discussed, could occur in the Court of Session in similar cases.

The law of delict operates in both Scotland and South Africa due to analogous legal histories in those jurisdictions,[73] which begs the question whether there is a more direct route. It is instructive to consider the operation of the South African law on disclosure in medical practice in order to pose the question, 'Could it happen here?' – if only to discount that

[72] Consider Griffiths, John R. 'Consent - Scots Law and the Patient's Right to Know.' (1996) 15 *Medicine and Law* 1-6.
[73] K Zweigert & H Kötz *Introduction to Comparative Law*. 1987. Clarendon Press. Oxford. 64 et seq.

possibility.

6.4.1. JUDICIAL POLICIES: COMPARING SCOTLAND AND SOUTH AFRICA

To recap, in *Richter v Estate Hammann*, Watermeyer J had upheld the standard of the reasonable medical practitioner as the test for the legal standard of care. That remained judicial policy[74] until the appeal judgement in *Castell v DeGreef*[75] in which the court approved of the decision in *Rogers v Whitaker* and of the stance of Lord Scarman in the *Sidaway*.

The judgement in *Castell v DeGreef* was based on the South African law of delict and, on policy grounds, the court allowed the defence of *volenti non fit iniuria*. Ackerman J also argued that there existed a line of precedent to the effect that cases which has to do with consent to medical treatment fall under the *volenti* defence, which would justify an otherwise wrongful delictual act.[76]

Having allowed the defence to proceed, the court held that it succeeded and that the patient had therefore given her informed consent to the surgery. The addition made in the case law is this: the test used by the court to establish whether the information on the inherent risk suffered was material information, was a carbon copy of the test set out in *Rogers v Whitaker* in Australia. In other words, a material risk is one to which a person in the plaintiff's position would be likely to attach significance *or* one to which a medical practitioner might reasonably be expected to be aware that the patient would find significant.[77]

This is a matter of the sequence of the legal argument. If the pleadings are in negligence then the relevant negligence tests will be brought to bear on the case; in the case of Scotland this means the test in *Hunter v Hanley and Moyes v Lothian Health Board.* If, on the

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[74] Cf. *Blyth v van den Heever* 1980 (1) SA 192, 220-21. When confronted with the question as to what constitutes negligence in the medical arena, Corbett, JA set out a *Bolam* style test, albeit in the therapeutic context.

[75] 1994 (4) SA 408.

[76] Many of these cases have already been discussed in this thesis. They include, *Stoffberg v Elliot* 1923 CPD 148, *Lymbery v Jerreries* 1925 AD 236, *Lampert v Hefer* NO 1955 (2) SA 507 (A) and *Richter v Estate Hamman*.

[77] *Castell v DeGreef* 1994 (4) SA 408, 426G. Cf. 3.3.3. and *Rogers v Whitaker* [1993] 4 Med LR 79, 83 (col.ii).

other hand, the pleadings allege that the proper legal category for disclosure cases is in wrongfulness itself, and that argument is accepted, then consent emerges as a *defence*. Accordingly, the doctrine of *volenti non fit iniuria* became a way of testing the reality of consent as a matter of fact.

The South African judiciary found in *volenti* a legal category for consent and risk-taking. On policy grounds, the Court used it to test whether consent had been given. This involved a *post facto* inquiry and allowed the Court to escape the category of negligence. In the South African context, the wrongfulness is not negligence but comprises the failure to warn of a material risk. What is important here, from ideological and precedent points of view, is the ability of a judiciary to adapt a doctrine to fit its own jurisprudential needs - and indeed to adapt the *volenti* defence to fit the medical scenario.

6.4.2. *VOLENTI*, NEGLIGENCE AND *CULPA*

If the action is for breach of duty and is an action *ex delicto*,[78] that is not to say that the action is necessarily in either negligence or assault. If the court holds the duty of care to encompass consent based on information, in the law of delict it does not follow that this should be argued in negligence. This is about a failure to carry out the duty of care effectively by ensuring that the patient is adequately informed so as to have given an understood consent. The difference is that the delict is constituted by acting without consent where the duty of care demands consent; and consent is something which is to be tested differently to negligence *simpliciter*. The test for the reality of that consent has its basis in the *volenti* defence.

The *volenti* defence may appear anomalous in the context of informed consent because of its relation to contributory negligence, but being *volens* depends on both knowledge of the risk involved as well as the acceptance thereof. In assessing whether a patient was or was not *volens*, the court then interrogated the adequacy and materiality of the information given, by reference to its own criteria. This involved not only an adaptation of the test for the standard of care as expressed in *Rogers v Whitaker* to make that test compatible with *volenti*; it also involved an adaptation of conventional understandings of *volenti non fit iniuria* so that its

[78] *Edgar v Lamont* [1914] SC 277

mechanism could be used in the context of consent to the risks inherent in surgery.

This means that despite the fact that in other common law jurisdictions, imperfect consent may constitute negligence, in South Africa it effectively constitutes wrongfulness. The use of *volenti* had two effects other than removing the issue from the realm of negligence, if temporarily. It placed the disclosure and materiality of risk in a contractual context and it shifted the evidentiary burden onto the defender who must show that on balance of probabilities the plaintiff was *volens*.[79] This is done by showing that, in terms of judicial criteria, the plaintiff had in fact made a 'conscious, deliberate, informed and voluntary decision to run a known risk [which is] therefore in its nature subjectively determined.'[80]

It has been argued in Chapter 3 that when the question of causation is confronted under *volenti*, it does not involve a policy-guided inquiry into legal causation, because factual and legal causation are subsumed in this aspect of the law of delict. Causation is established inferentially and is proven the way *res ipsa loquitur* proves negligence, such that participating in surgery objectively amounts to causation of the injury because the duty of care is fulfilled where a person is deemed to be *volens*. Considering the use of the law of delict and the *volenti* defence in South Africa, the question arises as to whether Scotland has by analogy and systemic similarity another possible route to informed consent through *volenti non fit iniuria*.

6.4.3. SCOTS LAW

There are many cases in Scots law on the voluntary assumption of risk in judicial inquiries into contributory negligence and causation,[81] but none consider the matter of consent to medical procedures. The issue is *consent*: the defence of consent and the delict of causing injury while acting without complete consent where the duty of care demands it.

It is clear from *Reibl v Hughes* and *Rogers v Whitaker* that a different test or standard is needed for issues of consent and for matters in which negligent performance of the medical

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[79] P Q R Boberg *The Law of Delict*. 1984. Juta. Johannesburg. 767-8.

[80] P Q R Boberg 'Some Light on the Defence of Volenti.' (1974) 91 *SALJ* 19, 27.

[81] *Tichener v British Railways Board* 1984 SC (HL) 34, 1984 SLT 192. In the context of health, in *McTear v Imperial Tobacco Ltd, The Times*, September 30, 1996 (Inner House) it was held that the pursuer had voluntarily assumed the risk of lung cancer by smoking the cigarettes manufactured by the defender.

procedure is alleged. According to *Moyes*, the test in *Bolam* and *Hunter v Hanley* is to be applied in Scots law in both scenarios.[82] In South Africa, on the other hand, *volenti* provided an alternative test which in itself was able to distinguish instances in which injury was caused by lack of information from instances in which injury was caused by the negligent performance of the medical procedure in question.

Informed consent cases under *volenti* give rise to an action in consent itself. In *Castell v DeGreef*, the court used a test for materiality taken from *Rogers v Whitaker*. This injected a normative facet into the judicial inquiry which is at odds with *volenti non fit iniuria*, because *volenti* is a question of fact which asks whether this patient knew of the particular risk which did in fact eventuate. Materiality, on the other hand, is a normative test relative to the patient's views or relative to the practices of the notional reasonable medical practitioner.

There is a difference between assessing the reality of consent in a case before the court and creating criteria to be used in the future by doctors and lawyers, which is the normative facet of the matter and involves an assessment of materiality.[83] Whatever the test for materiality, the court will still have to ask whether it was reasonable for the doctor to have failed to disclose a particular risk. Even although it has been rightly hailed as progressive by those protective of 'patient autonomy',[84] the *Castell v DeGreef* decision sets out a *post facto* decision-making mechanism. The criteria used under *volenti* are assessments of whether the patient had knowledge of a certain risk. This is of little help to the doctor in the consultation situation when asking what information might be required.

All disclosure cases turn on whether information is or is not supplied and hence a definition of 'materiality' is required. As soon materiality is defined and that definition is judicially applied, the matter becomes normative. But because normativity and *volenti* appear mutually exclusive, this makes for somewhat incongruent law.

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[82] It has been argued that by siding with a test for legal causation like that in Canada, the English judiciary is separating the two scenarios, though not at the level of the duty of care.

[83] This will be discussed in the final chapter of this thesis.

[84] See F F W van Oosten '*Castell v De Greef* and the Doctrine of Informed Consent: Medical Paternalism Ousted in Favour of Patient Autonomy.' (1995) 28 *De Jure* 164. This case was hailed as protective of patients'

The difference between the decisions in Scotland and those in South Africa is seen at the policy level. In Scotland, policy decisions are made in a manner in which the policy of the court tends to emerge from the decision itself. In adopting a view on informed consent in which materiality is assessed from the point of view of the reasonable practitioner, courts have hitherto adopted a policy favourable to the medical profession, though this is itself in jeopardy. The South African court, on the other hand, considers policy more overtly and in the opposite sequence by starting off with a position it deems desirable and then considering a possible legal peg on which to hang that policy.

Another difference which is evident is in the tendency of the South African courts to use academic writings and foreign decisions to justify judgements. This makes the South African law of delict more comparative than the Scots law of delict. A further difference involves the use of alternative tests for the duty of information and the duty of care in negligence *simpliciter.* This occurred in *Castell v DeGreef* through the use of *volenti* in consent cases. In *Moyes v Lothian Health Board*, in the other hand, the Court of Session held that the same test - in *Hunter v Hanley* and *Bolam* - is to be used on both instances. This means that for Scottish courts to go the route of the South African judiciary, would require extreme judicial activism which would go against existing precedent.

Even if Scotland were to see *volenti* as supplying criteria for consent, it is unlikely that the Court of Session will adopt what is essentially a contradiction of two legal categories. Additionally, Scottish courts may be unlikely to follow the South African lead because they do not tend to begin judgements with a policy decision. This indicates a greater tendency to adhere to the operation of the common law and the doctrine of *stare decisis.*

This line of precedent in Scottish common law requires disclosure cases to be litigated as negligence matters, rather than as wrongfulness matters. To be able to tread the path of the South African Courts would require the Scottish Judiciary first to see the informed consent

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rights even although the plaintiff did not win her case but failed on causation. Even so, the adoption of the test in *Rogers v Whitaker* is what rendered the case 'progressive'.

scenario as an issue of consent and wrongfulness which is not negligence[85] and to separate the tests for negligence *simpliciter* from those based on information disclosure. There is no Scottish precedent for this, but there is precedent to the contrary.

That said, it is arguably possible to change the legal position in Scotland on the basis of policy. This argument proceeds from the basis that Scottish courts do at times engage in 'judicial activism' which could conceivably lead to a change in judicial orientation from one favouring the medical professional to one favouring the patient, even although this seems unlikely.

The Court of Session has indicated that in some instances a desirable policy might be in evidence which has been supported by another comparable jurisdiction and is therefore worthy of adoption by the Scottish courts.[86] Though this has not yet occurred in medical negligence cases, it has occurred in the law of obligations. *Smith v Bank of Scotland*[87] concerned the constructive notice of a husband's misrepresentations and the failure of a bank to warn his wife of the risk of granting security for her husband's debts, as well as the failure to recommend independent legal advice. The analogy fits: there was an obligation to provide information, the omission to do so and the resultant harm.

What is important to the present argument is that the court in *Smith* considered *Barclays Bank plc v O'Brien*[88] which was a ruling in England. The court found the policy underlying that decision to be a favourable one and imported it to affect a change in the legal doctrine north of the Border. From this argument, it is not entirely fanciful that the Court of Session should consider a South African ruling which adopted a policy with which the court agreed and so to consider the South African precedent to be of sufficient weight to change the legal rule in Scotland.

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[85] *Castell v DeGreef* was a negligence case from beginning to end, but one in which the court made a detour through wrongfulness, as the court did in *Rogers v Whitaker* when considering trespass.
[86] See Macgregor, L. 'The House of Lords "Applies" O'Brien North of the Border.' (1998) 2 *Edinburgh Law Review* 90.
[87] 1997 SLT 1061 (HL).
[88] [1994] 1 AC 180.

This means that the court could consider the matter as one of wrongfulness by drawing on the law of delict. It would then need to define materiality and it is that element which would have its basis in judicial policy. This would be the most difficult obstacle because of an existing policy which is protective of the medical profession and which is in evidence through the case law from *Hunter v Hanley* to *Goorkani*. Such a move would require a departure from existing policy, but on the basis of *Smith v Bank of Scotland*, it is argued that such a departure is possible in law, though perhaps improbable in practice.

On balance it is argued that the Scottish judiciary will more probably follow the English 'erosion' cases because the resultant change in the legal position is slow and incremental and will not ruffle as many feathers as an approach which is based on such extreme judicial activism.

6.5. CONCLUSION

The main concern of this chapter has been to explore the possibilities in disclosure law in the United Kingdom. It was argued that but for judicial policy, some of the American extremes highlighted in this chapter could become part of the informed consent case law in those countries where the doctrine has been adopted. In respect of England and Scotland, the question is of a different order because those jurisdictions are not yet at the top of the same slippery slope. This is why one can posit the American extremes as a reason not to adopt the doctrine.

Because British jurisdictions decided not to adopt the doctrine, this chapter sought to explore possible routes to the piecemeal absorption of consent principles – perhaps those based on the doctrine of informed consent. The argument which was followed was based on the fact that the medical profession is adopting an increasingly patient oriented disclosure standard. In the context of the tests in *Bolam* and *Hunter v Hanley*, this means that this standard will become the legal standard. As such omissions become medically unreasonable, they will become judicially unreasonable, and hence negligent. The medical profession and the judiciary will be guided in this increasingly patient-centric assessment, by the existing case law – both domestic and foreign - and by positive law such as the European Convention on Human Rights and Biomedicine.

This is all possible in British courts because of the policy that holds medical evidence to be subject to judicial scrutiny and assessment. The basis for that argument is the decision in *Bolitho*, coupled with those in the 'erosion' cases. This argument applies equally to England and Scotland.

However, because of the operation of the *volenti* defence and its admissibility as a defence in South African law, this chapter explored the possibility of its importation into Scots law. However, because the weight of precedent swings the other way, the law in Scotland will probably not follow that route despite the argument, based on *Smith v Bank of Scotland*, that the judiciary could choose a more active role in upholding patients' rights.

CHAPTER 7

CONCLUSION

7.1. INFORMED CONSENT IN LAW

What has been attempted in this thesis is a deconstruction of a relatively small area of law in respect of those jurisdictions among which the law is seen as comparative. Not only does the law on disclosure have to do with the civil law; it has to do for the most part with the law of negligence. More specific still, it has to do with medical negligence insofar as the allegation would be that because of the medical practitioner's negligent omission to disclose to the patient information on a particular risk which eventuated, that patient suffered injury which was causally linked to that risk. Bearing, as he would, the burden of proof, that patient would have to satisfy the court that the presence of that piece of information would have broken the chain of causation between the negligent omission and the injury suffered. This would entail persuading the court that a different course of action would have been taken, had the absent information been present. That, as we have seen, depends on the test used by the court which, in turn, depends on the policy adopted by the courts in each particular jurisdiction.

In analysing the different policy implications of the judgements of the jurisdictions covered, this thesis has embarked on a deconstruction of the relevant case law, but has sought to link those cases to cases from other branches of law where relevant. This has been an exercise in deconstruction of the *minutiae* of a small area of the common law. One would hesitate to submit that this deconstruction has been in the sense envisaged by Derrida.[1] However, the subject matter has been approached from a *gestalt* point of view; the whole is considered to comprise more than the sum of its parts. The reason for this is the operation of judicial policy, which at times leads to judicial activism.

For this reason, this thesis has at times integrated links to other areas of the law in order to support the principles relied upon. This is particularly true in respect of the penultimate

[1] In the sense discussed in, Derrida, J. *Acts of Literature*. London. Routledge, 1992 and Derrida, J. (John D. Caputo, Ed.) *Deconstruction in a nutshell: a conversation with Jacques Derrida*. New York. Fordham University Press. 1997

chapter. In order to understand that the informed consent scenario or the law on medical information disclosure is adjudicated according to the law of negligence, one has to exclude the criminal law on the one hand and, on the other, one has to exclude the law pertaining to intentional delicts. This speaks to the exclusion of the law on assault. The policy implications of this categorisation were discussed in the opening chapter.

From there, one was able to delve into the finer points of what the law has to say on unintentional delicts, as well as their defences - including *volenti non fit iniuria.* Through this inquiry it became apparent that the major sticking point is neither in the test for the standard of care, nor is it in the test for factual or legal causation. Indeed, the most controversial point is the form of test adopted for *materiality*; in the case of British jurisdictions, the question is whether or not the adoption of any test for materiality is appropriate.

It is at the point of materiality that the doctrine is expanding in some American jurisdictions to include fact scenarios which were perhaps not envisaged by the bench in *Canterbury v Spence.* It is at that point that a modified objective test was employed in Canada in *Reibl v Hughes.* It is at that point that the South African court in *Castell v DeGreef* adopted the Australian decision in *Rogers v Whitaker* which was itself a modification of the test in *Reibl v Hughes* - and indeed *Canterbury v Spence.*

The test for materiality lies between the standard of care and causation inquiries and is applicable to both. In terms of the standard of care there would, according to the doctrine, be a duty to warn of material risks. However, a risk is material if it would affect a decision on treatment; this is pivotal to the inquiry into legal causation.

In Britain, it is difficult to escape a definition of materiality for long. There is a gravitation within professional opinion towards more comprehensive disclosure in medical practice which, it has been argued, will lead to non-disclosure being considered unreasonable by the medical profession. With the emergence of such a position, the tests in *Bolam* and in *Hunter v Hanley* would not support a medical practitioner who omitted to disclose a particular (material) risk. In Scotland, a definition of materiality is necessary even if the court were to follow the South African lead and consider the matter as one of wrongfulness in failing to procure an informed consent, rather than as a matter of negligence. In law, this is theoretically

possible on the basis of the principles iterated in *Castell v DeGreef* and *Smith v Bank of Scotland.*

In the United Kingdom, materiality is a medical standard. As such, it need not be expressly defined as a legal test. This is because the *Bolam* test is a floating benchmark and is adaptable to current medical practice. This means that as more comprehensive disclosure becomes the accepted standard in medical practice, more patient-centric consent principles will be taken on board by the law. Hence, the law will be able to adopt a form of the doctrine of informed consent if a responsible body of medical practitioners supports it *and* if no responsible body of medical practitioners supports non-disclosure. This is more akin to the wording of the test in *Hunter v Hanley* than it is akin to that in the *Bolam* test.

Nonetheless, one would still be looking for a legal test which is able to be understood by members of the medical profession. This is because the test itself affects and guides medical practice. Whichever test is supported by the law, the matter of legal policy and judicial activism cannot be ignored. If it is essentially defensive medical practices in Britain which usher in the perceived need for more comprehensive disclosure, one would be forced to reconsider arguments which hold that defensive medicine is a negative transatlantic import. In the light of the argument presented in this thesis, defensive disclosure practices would appear to be supportive of the rights of the patient which are seen to exist *sui generis*. Judicial sanction of these practices through the *Bolam* test would require simply that medical practitioners 'move with the times'.

7.2. INFORMED CONSENT IN MEDICAL PRACTICE

Because the doctrine of informed consent is a legal doctrine - albeit adapted to fit the strictures of the domestic jurisprudence of each jurisdiction covered - it is important that members of the medical profession understand its tenets in their own jurisdiction. This is so regardless of whether the doctrine is rejected, accepted or adapted because it is a legal standard with which members of the medical profession must comply. It is therefore important to consider not so much which of the tests discussed is more equitable in terms of the allegedly competing interests of patient and practitioner,[2] but which test provides the medical practitioner with guidelines which are easy to follow. This is a matter of legal certainty which should lead to

greater certainty in medical practice.

7.2.1. THE UNITED STATES OF AMERICA

It was argued in Chapter 4 that American jurisdictions differ among one another on the appropriate test for materiality and that they exhibit the same disunity as that exhibited among the other jurisdictions covered by this thesis.

7.2.2. CANADA'S 'MODIFICATION'

What the Canadian Supreme Court did in *Reibl v Hughes* was not to modify the test inherent in the doctrine as outlined in *Canterbury v Spence.* What the court did was to modify the existing subjective test inherent in the law of torts in Canada - specifically in negligence. This in itself created a judicial test which was different from that employed in negligence *simpliciter.* The question is, 'is the test useful to the medical practitioner?'

In requiring the disclosure of material risks and then defining a material risk as one to which the reasonable patient in the plaintiff's position would attach significance, the court raised the legal expectation and extended the civil liability of medical practitioner. This is in itself nothing new because of the raised standard of care inherent in the law of negligence as applied to the medical practitioner. It is submitted that this test is one which the medical practitioner will find useful because the medical practitioner can place him-or herself in the position of the reasonable patient, without making too much of an imaginative leap. It is this test, which seeks to exclude hindsight, which the Canadian courts have adopted and that by which the Canadian medical practitioner will have to abide.

7.2.3. AUSTRALIA'S AMBIVALENCE

The matter is more complex in Australia. Again there is a duty to warn of material risks inherent in the medical procedure to be performed. However, in *Rogers v Whitaker* the Australian High Court defined a material risk as one to which the subjective patient would attach significance *or* one which the court would expect the reasonable doctor to know would be significant to the patient.

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[2] This has been considered throughout this thesis.

It is argued that this ambivalence makes for a test which is difficult for the medical professional to use. How, for example, could that practitioner know which side of the test the court would use? Would it be the first part, the second, or both? The facts of the case might render these questions irrelevant, but different facts might lead to concern on the part of members of the medical profession.

Use of the first part of the test would amount to a very high expectation of the doctor; the law would require a medical practitioner to know in some detail the value system of each patient. While courts consider this value system at proof, they do so over several days or weeks. To expect that of the medical practitioner would be to place a heavy burden on the profession as a whole. Use of the second part of the test reinforces the first and, it is argued, has the same effect because in practice the subjective standard is employed first and then turned into an objective expectation of the doctor.

7.2.4. THE SOUTH AFRICAN SIMILARITY

The position in South Africa was complicated by the use of the defence of *volenti non fit iniuria* in *Castel v DeGreef*. However, the test for materiality is the compelling point in the judgement for the reasons stated in this thesis.[3] On that point, the test in *Rogers v Whitaker* was adopted *verbatim* and hence the same argument advanced in respect of the Australian position, may be advanced in respect of the South African position: that as a legal guideline, the test is not as useful to the medical practitioner as the Canadian test.

7.2.5. THE BRITISH TRADITION

In Britain the test is that set out in *Bolam* and in *Hunter v Hanley*, as supported by *Sidaway* and *Moyes v Lothian Health Board*. It is the medical professional standard. Without saying it in so many words, the court tested materiality of information relative to the opinions of reasonable and responsible members of the medical profession.[4] This makes the test in the United Kingdom the easiest to use by members of the medical profession.

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[3] Cf. inter alia 3.3.

[4] Though Lord Scarman did discuss this to some extent in *Sidaway*. Cf. 3.3.4.

Many arguments have been advanced in this thesis and elsewhere which place a value judgement on the use of the *Bolam* test. It has been castigated as paternalistic and as archaic. However, it was argued in Chapters 5 and 6 that it is precisely the fact that the test constitutes a floating benchmark that is the strength of the test. While British jurisdictions will continue to resist judicial importation of the doctrine of informed consent for the reasons outlined in this thesis, the judiciaries will be unable to resist the importation of the principles inherent in the doctrine where members of the medical profession support those principles, or consider them part of UK law.

This is a position which is backed up by the recent case law. The *Sidaway* case remains the benchmark case on informed consent, along with its support of the *Bolam* test. However, it is evident from subsequent judgements handed down by courts inferior to the House of Lords, that the *Bolam* test is proving useful to plaintiffs and pursuers on the matter of negligence. *Smith v Tunbridge Wells*, *Newell and Newell v Goldenberg*, *McAllister v Lewisham* and *Goorkani v Tayside Health Board* support the view that medical practitioners may be held liable in negligence despite – or indeed because of – the *Bolam* test. In these cases plaintiffs did face the additional hurdle of proof of causation. At that point, the law began to resemble that in Canada by taking the views of patients into account in respect of what action would have been take had they known of the risk which eventuated.

What remains important is the fact that the court has always asserted its authority to decide on reasonableness – and indeed on the probable actions of the reasonable patient – when considering both liability in negligence and causation. That this is the case is evident from the House of Lords judgement in the *Bolitho* case, in which the House reiterated its authority to decide matters using the legal application of a reasonableness test. Even although *Bolitho* was not an informed consent case, the judgement is important from the point of view of the court's use of that authority and the application of the *Bolam* test to the causation inquiry. For the purposes of this thesis, this is important because it is symptomatic of the court's ability to adjudicate informed consent matters on the basis of reasonableness which in itself may lead to the *Bolam* test proving useful to the patient. This relatively new use of the *Bolam* test marks a difference in the behaviour of the courts towards the doctor-patient relationship. Whereas before the cases mentioned in the above paragraph, the *Bolam* test was seen as protective of members of the medical profession, it may now be seen as the floating benchmark it has been argued to be in this thesis. This, coupled with the assertion in the *Bolitho* judgement, of the

court's authority to so adjudicate, heralds a move in medical jurisprudence towards more account being taken of patients' views, while at the same time not adopting the doctrine of informed consent *per se*.

This is a form of judicial activism quite unlike that demonstrated in Canada, Australia and South Africa in which the doctrine was adopted or adapted, though other forms of judicial activism remain open to the courts. It was argued in Chapter 6 that a form of judicial activism other than the use of the *Bolam* test as a floating benchmark, may be open to Scots law. The judgement in *Smith v Bank of Scotland* serves as evidence of the possibility of importation of a set of legal principles on information disclosure, from another jurisdiction. Whether or not this will ever happen is a moot point, though the possibility remains open.

7.2. CONCLUSION

All that is required of medical practitioners is that they 'move with the times'.[5] As a legal principle, this is no different among the jurisdictions covered here. If, by moving with the times and accepting the principles which underlie the doctrine of informed consent, medical practitioners adopt essentially defensive practices, then so be it. These practices can be justified from the point of view of the protection of patients' rights to information and can be supported by the tests in *Bolam* and *Hunter v Hanley*.

One can therefore argue that if medical practitioners simply keep up to date with current practices in respect of disclosure of information to patients, viewed both domestically and globally, then informed consent is on its way here. It is on its way without the court having to create a test which is different in respect of negligence *simpliciter*, from that which is applicable to disclosure cases. This is because in negligence *simpliciter* the medical practitioner is expected to keep up to date with the practices and techniques of his colleagues.

In the final analysis, even although this thesis has argued in favour of the *Bolam* test, the conclusion remains the same as many other works on the subject which favour a patient-centered approach to information disclosure in the medical context. It .is still a question of

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[5] That this is the case is evident from *Roe v Minister* of Health [1954] 2 All ER 131 in which it was held that the court is not permitted to look back with a 'retrospectoscope'. This judicial witticism argued that the court must not look at an accident which occurred in 1947 through '1954 spectacles'.

whether we, as a society rep[resented by the judiciary, are willing to leave such matters in the hands of the medical profession, even although they seem to be adopting a more patient-oriented approach in practice. The pendulum has in the last few years begun to swing in favour of the patient, and has done so precisely through the *Bolam* test. However, leaving the *Bolam* test in its present form and position of authority provides no guarantee - other than continuous assertions of judicial dominance over the *application* of the test – that the pendulum will not swing back to its former position. Perhaps by that time, however, judiciary and medical profession will see, through comparative spectacles, such a regression in policy as counter-productive folly.

BIBLIOGRAPHY

Balen, Paul. 'Consent to Medical Treatment' (1994) 138 *Solicitors Journal* 121-123.

Bashook, Philip G. & Parboosingh, John. 'Continuing Medical Education: Recertification and the maintenance of competence', *British Medical Journal* 1998; 316: 535-548 (14 February).

Beecham, Linda. 'GMC approves new ethical guidance' (1998) 316 *British Medical Journal* 1553.

Beecham, Linda. 'Self regulation of doctors must work locally' (1998) 316 *British Medical Journal* 1477.

Bell, John. *Policy Arguments in Judicial Decisions.* 1983. Clarendon Press. Oxford.

Bentham, Jeremy. *Treatise on Judicial Evidence.* 1825. *Of Laws in General* edited by H.L.A. Hart. 1970. London. Athlone Press.

Boberg PQR. *The Law of Delict.* Juta. Johannesburg. 1984.

Boberg PQR 'Some Light on the Defence of Volenti.' (1974) 91 *South African Law Journal* 19.

Brahams, Diana. 'Aids and the Law'. *New Law Journal.* 14 August 1987.

British Medical Association. *Medical Ethics Today: its Practice and Philosophy.* 1993.

Carter, J W & Harland, K E. *Contract Law in Australia* (3ed.). Sydney. Butterworths. 1986.

Chalmers, Don & Schwartz, Robert. '*Rogers v Whitaker* and Informed Consent in Australia: a Fair Dinkum Duty of Disclosure' (1993) 1 *Medical Law Review* 139.

Cohen, R S & Schnelle, T. (Eds.). *Cognition and Fact: Materials on Ludwig Fleck.* 1986. Kluwer Academic Publishers. Dordrecht.

Dahrendorf, Ralph. 'Defence of English Professions'(1984) 77 *Journal of the Royal Society of Medicine* 178.

Dean, M. (1993) 341 *The Lancet* 883.

Derrida, J. *Acts of Literature.* London. Routledge. 1992

Derrida, J. (John D. Caputo, Ed.) *Deconstruction in a nutshell: a conversation with Jacques Derrida.* New York. Fordham University Press. 1997.

DiCaccavo, A & Reid, F 'Decisional Conflict in General Practice: Strategies of Patient Management' (1995) 45 *Social Science and Medicine* 347-353.

Dickens B M *Justice Beyond Orwell.* 1985. Les Editions Yvon Blais Inc. Montreal.

Digby, Anne. *Making a Medical Living: doctors and patients in the English market for medicine, 1720-1911.* Cambridge. Cambridge University Press. 1994.

Dodd, F J. et al, 'Consensus in Medical Communication' (1993) 37:4 *Soc. Sci. Med.* 565-569.

Dowling, S, Barrett & West, R 'With Nurse Practitioners, Who Needs House Officers?' (1995) 311 *British Medical Journal* 309.

Downie R S & Charlton, Bruce *The Making of a Doctor.* 1992. Oxford University Press.

Dupuy J 'On the Supposed Closure of Normative Systems' in Teubner G *Autopoietic Law: a New Approach to Law and Society.* 1988. Walter de Gruyter. New York.

Durkheim, Emile. *Professional Ethics and Civic Morals.* 1992. Routledge. London.

Dyer, Clare. 'Consultant suspended for not getting consent for cardiac procedure' (1998) 316 *British Medical Journal* 955 (28 March).

Clare Dyer 'Surgeon blamed beginner's bad luck for cardiac deaths' (1998) 316 *British Medical Journal* 1111.

Earle, Murray 'Informed Consent: Is There Room For the Reasonable Patient in South African Law?' (1995) 4 *South African Law Journal* 629.

Economist. August 19th 1995.

Elliott P. *Sociology of the Professions.* London. Macmillan. 1972.

Feenan D K 'Medical Negligence: *Hunter v Hanley* 35 years on: a reply' 1991 *Scots Law Times* 321.

Tan Keng Feng. 'Failure of Medial Advice: Trespass or Negligence.' (1987) 7 *Legal Studies* 149.

Forsythe, Gordon. *Doctors and State Medicine* (2ed). 1973. Pitman Medical. Oxford.

Foucault, Michel. *The Archaeology of Knowledge.* Routledge. New York. 1972.

Gee, D J & Mason, J K *The Courts and The Doctor.* 1990. Oxford University Press. Oxford.

General Medical Council. *Duties of a Doctor.*

Giesen, D. *International Medical Malpractice Law.* Mohr. Nijhoff. 1989.

Giesen J & Hayes J 'The Patient's Right to Know - a Comparative View' (1992)21 *Anglo-American Law Review* 101.

Gillon, R 'Consent' (1985) 291 *British Medical Journal* 1700.

General Medical Council. *Professional Conduct and Discipline: Fitness to Practice.* 1987.

General Medical Council. *Good Medical practice*. 1998.

General Medical Council. *Seeking Patients' Consent: the Ethical Considerations.* 1999.

Goldrein, Iain S. 'Bolam - Problems Arising Out of "Ancestor" Worship' (1994) 144 *New Law Journal* 1237.

Griffiths, John R. 'Consent - Scots Law and the Patient's Right to Know.' (1996) 15 *Medicine and Law* 1-6.

Hart H L A & Honoré, T. *Causation and the Law*. (2 Ed.) 1985. The Clarendon Press. Oxford.

Hall, O. 'The Internal Organisation of the Medical Profession' (1946) 22 *Canadian Journal of Economics and Political Science.*

Halsbury's Laws of England.

Hart, H L A and Honoré, T. *Causation and the Law*. (2 Ed.) 1985. The Clarendon Press. Oxford.

Herman, J. 'Beyond Positivism: A Metaphysical Basis for Clinical Practice?' (1992) 39 *Medical Hypotheses* 63-66.

Hoffer, P C & Hull, N E H. *Murdering Mothers: infanticide in England and New England 1558-1803.* New York University Press. New York. 1984.

Honoré, Tony. 'Hermogenianus on Privity and the Scope of the Law of Contract' (1991) *Current Legal Problems* 135.

Honoré, Tony. 'Causation and Disclosure of Medical Risks', (1998) 114 *Law Quarterly Review* 54.

Hood, Catherine A, Hope, Tony & Dove, Phillip 'Informed Consent in Medical Research – videos photographs and patient consent', (1998) 315 *British Medical Journal* (28 March 1998).

Howarth, David. *Textbook on Tort*. Butterworths. London. 1997.

Irwin S., Fazan C. & Allfrey, R. *Medical Negligence Litigation*. 1995. Legal Action Group. London.

Jackson, Rupert M. & Powell, John L. *Jackson and Powell on Professional Negligence (3ed).* London. Sweet & Maxwell. 1992.

Johnson Terrence, J. *Professions and Power.* 1972. MacMillan. London.

Jones M A. 'Medical Negligence - the Burden of Proof' (1984) 134 *New Law Journal* 7.

Kaufmann, Caroline L. 'Informed Consent and Patient Decision Making: Two Decades of Research' (1983) 17:21 *Soc. Sci. Med.* 1657-64.

Kennedy, Ian. 'The Patient on the Clapham Omnibus' (1984) 47 *Modern LawReview* 454.

Kennedy, Ian & Grubb, Andrew. *Medical Law: Text with Materials*, 2nd ed. Butterworths. London. 1994.

Kennedy, Ian & Grubb, Andrew. 'The New Bolam', (1995) 2 *Medical Law Review* 197.

King, M. 'The Truth about Autopoiesis' (1993) *Journal of Law and Society*. 218.

Kirby, M.D. 'Informed Consent: What Does it Mean?' (1983) 9 *Journal of Medical Ethics*. 69-75.

Ladeur K 'Perspectives on a Post-modern Theory of Law: a Critique of Niklas Luhmann, "The Unity of the Legal System"' in Teubner G *Autopoietic Law: a New Approach to Law and Society*. 1988. Walter de Gruyter. New York.

Law Reform Commission of Canada. *Consent to Medical Care*. 1980.

Lidz, Charles W. et al. *Informed Consent: a Study of Decision Making in Psychiatry*. The Guildford Press. New York. 1984.

Linden, A M *Canadian Tort Law* (3Ed.) Butterworths. Toronto. 1992.

Lloyd-Morris, Syvil. 'The Age of Consent' (1991) 141 New *Law Journal* 426

Luhmann N (1988a) 'Closure and Openness: on Reality in the World of Law' in Teubner G *Autopoietic Law: a New Approach to Law and Society*. Walter de Gruyter. New York. 1988.

Luhmann N (1988b) 'The Unity of the Legal System' in Teubner G *Autopoietic Law: a New Approach to Law and Society*. Walter de Gruyter. New York. 1988.

MacFarlane P. *Health Law - Commentary and Materials*. The Federation Press. NSW. 1993.

Macgregor, L. 'The House of Lords "Applies" O'Brien North of the Border.' (1998) 2 *Edinburgh Law Review* 90.

Markesenis, B S. (Ed.) *The Gradual Convergence: foreign ideas, foreign influences, and English law on the eve of the 21st century*. Clarendon Press. Oxford. 1994.

Markesinis B S & Deakin S F. *Tort Law* (3 Ed.). Oxford. New York. 1995.

Mason, J K. 'Legal Aspects of Medical Practice' in *Forensic Medicine for Lawyers*. (4ed) London. Butterworths. 1996.

Mason, J K & McCall Smith, A S. *Law and Medical Ethics (4ed)*. London. Butterworths. 1994.

Matby, J R & Eagle, C J. 'Informed Consent for Clinical Anaesthesia Research' in (1993) 40 *Canadian Journal of Anaesthesia*. 891-6.

Matthews, J Rosser. *Quantification and the Quest for Medical Certainty*. Princeton University Press. 1996.

Maxwell, Robert J. 'South Africa: a Fragile Miracle' (1995) 345 *Lancet* 1222.

McLean, Sheila A M *A Patient's Right to Know: Information Disclosure, the Doctor and the Law*. Aldershot Brookfield, VT; Dartmouth, Gower. 1989.

Meadow, William L. et al 'Ought "Standard Care" Be the "Standard of Care"?' (1993) 147 *American Journal of Diseases of Children* 40-44.

Miller, Frances H. 'Denial of Health Care and Informed Consent in English and American Law' (1992) 18 *American Journal of Law and Medicine* 37.

Montange, Charles H. 'Informed Consent and the Dying Patient.' (1974) 8 *Yale Law Journal* 1632.

Nathan, the Rt. Hon Lord. *Medical Negligence*. Butterworth and Co. London. 1957.

Nelson-Jones, Rodney & Burton, Frank. *Medical Negligence Case Law*. Butterworths. London. 1995.

Nerhot P 'The Fact of Law' in Teubner G *Autopoietic Law: a New Approach to Law and Society*. Walter de Gruyter. New York. 1988.

Nieuw, A D. 'Informed Consent.' (1993) 12 *Medicine and Law*. 125-130.

Norrie K McK 'Standards of Disclosure' 1984 *Scots Law Times* 237.

Padfield, Nicola. 'Clean Water and Muddy Causation: is Causation a Question of Law or Fact, of Junt a Way of Allocating Blame?' [1995] *Criminal Law Review* 683.

Partridge, Eric: *Origins: a Short Etymological Dictionary of Modern English*. Routledge & Kegan Paul. London. 1958.

Patients Charter, The. 1992.

Pearson CH (chairman). Pearson Report: *Report of the Royal Commission on Civil Liberty and Compensation for Personal Injury* (Cmnd 7054)(1980) HMSO, London.

Powers, Michael J & Harris, Nigel. *Medical Negligence (2Ed.)* Butterworths. London. 1994.

Robertson, G. 'Informed Consent to Medical treatment' (1981) *Law Quarterly Review* 102-126.

Robin, Eugene D & McCauley, Robert F. 'Cultural Lag and the Hippocratic Oath' (1995) 345 *Lancet* 1422.

Salvage, Jane. 'What's Happening to Nursing' (1995) 311 *British Medical Journal* 274.

Scarry, Elaine. 'Consent and the Body' (1990) 4 *New Literary History* 867.

Schlesinger R B *Comparative Law* (2Ed.) Stevens & Sons Ltd. London. 1960.

Schultz, Marjorie Maguire. 'From Informed Consent to Patient Choice: a New Protected Interest.' (1965) 95(2) *Yale Law Journal.* 219, 224

Segest, E. 'Legal Aspects of Cases of Medical Malpractice in Denmark.' (1993) 12 *Medicine and Law* 617-25.

Shyrock, R. *The Development of Modern Medicine: an interpretation of the social and scientific factors involved.* Madison. University of Wisconsin Press. 1974 (1979 printing).

Slovenko, Ralph. 'Informed Consent: Information about the Physician.' (1994) 13 *Medicine and Law* 467-472.

Spencer & Flinn *The Evidence of Children* (2Ed.) Blackstone. 1992.

Marc Staunch. 'Causation, Risk, and loss of Chance in Medical Negligence.' (1997) 17 *Oxford Journal of Legal Studies* 205.

Stevens, R. *Medical practice in modern England : the impact of specialization and state medicine.* New Haven. Yale University Press. 1966.

Stewart W J. *An Introduction to the Scots Law of Delict.* W Green & Son. Edinburgh. 1989.

Strauss. 'Bodily injury and the Defence of Consent' (1967) 84 *South African Law Journal* 419.

Szasz, Thomas. 'Diagnoses are not Diseases' (1991) 338 *Lancet* 1574.

Teff, H. *Reasonable Care: legal perspectives on the Doctor-Patient Relationship.* Oxford University Press. Oxford. 1994.

Teubner G. Autopoietic Law: a New Approach to Law and Society. Walter de Gruyter. New York. 1988.

Teubner G. *Law as an Autopoietic System.* Blackwell. Oxford. 1993.

Thomson J M. *Delictual Liability.* Butterworths. Edinburgh. 1994.

Tindale, Francis & Cane, Peter. *The Law of Torts in Australia.* Oxford University Press. Melbourne. 1985.

van Oosten, F F W. 'Disclosure Documents and Informed Consent: the Pros and Cons.' (1993) 12 *Medicine and Law* 651-656.

van Oosten, FFW 'The Doctor's Duty of Disclosure and Excessive Information Liability.' (1992) 11 *Mecine and Law* 633 - 639.

van Oosten, FFW 'The Interaction Between Medicine and Law.' (1996) 14 *Continuing Medical Education* 10, 1459-1466.

Wadham, John & Mountfield, Helen. *Blackstone's Guide to the Human Rights Act 1998.*

Blackstone. London. 1999.

Walker, David M. *The Law of Delict in Scotland* (2Ed.) W Green & Son. Edinburgh. 1981.

Waltz & Scheuneman, 'Informed Consent to Therapy', (1970) 64 *N.W.U.L.Rev.* 628.

Watt I S, Howell D & Lo L. 'The health care experience and health behaviour of the Chinese: a survey based in Hull.' (1993) 15 *Journal of Public Health Medicine* 129-136 cited in (1998) 316 *British Medical Journal* (Editorial) 1476-1480 (16 May).

Watkins, S. *Medicine and Labour.*. Lawrence and Wishart. London. 1987.

Weber, Max. *The Theory of Social and Economic Organisation*

Wilson, The Hon. J O. *A Book for Judges.* Canadian Judicial Council. 1980.

Wittich, Dieter 'On Ludwig Fleck's Use of Social Categories in Knowledge', in Cohen, R S & Schnelle, T. (Eds.). *Cognition and Fact: Materials on Ludwig Fleck.* Kluwer Academic Publishers. Dordrecht. 1986.

World Health Organisation Technical Report Series, No. 838 *Increasing the Relevance of Education for health professionals.* 1993.

Zajicek, G. 'Normative Medicine' (1995) 45 *Medical Hypotheses* 331-334.

Zinn, Christopher. (1995) 311 *British Medical Journal* 709-10.

Zussman, R *Intensive Care.* Chicago University Press. Chicago. 1992.

Zweigert, K & H Kötz. *Introduction to Comparative Law.* Clarendon Press. Oxford. 1987..

APPENDIX A

'INFORMED CONSENT': IS THERE ROOM FOR THE REASONABLE PATIENT IN SOUTH AFRICAN LAW?*

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I INTRODUCTION

To *Bolam*,[1] or not to *Bolam*: that is the question:
Whether 'tis nobler in the Commonwealth to suffer
The slings and arrows of outrageous risk factors
Or to take arms against the views of doctors,
And by opposing quell them? To warn; to tell;
No more; and by inform to say we accept
The treatment, and know the thousand inherent risks
That flesh is prone to, 'tis a status
Devoutly to be wish'd.

It has been said that in law a 'phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon establishes it as a legal formula'[2] removed from its original context. Within medical practice, a patient's informed consent to a procedure is necessary for the physician's actions to be legal, but different jurisdictions interpret the doctrine of informed consent differently. The term 'informed consent' has been held in cases such as *Rogers v Whitaker*[3] in Australia and *Sidaway v Bethlem Royal Hospital*[4] in England to be meaningless or at least inapplicable. At the same time, the term is used by courts to uphold the ethical principle of self-determination which underlies the legal principle of informed consent to medical treatment. As a doctrine, it came from

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[1] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587, [1957] 2 All ER 118 at 122, in which McNair J outlined a now-canonized test for medical negligence in the therapeutic context: '. . . [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.' This test has subsequently been applied in the context of advice.

[2] Mr Justice Frankfurter in *Tiller v Atlantic Coast Line Railroad Company* 318 US 54 at 68, 87 L Ed 610 at 618 (1943), quoted in M D Kirby 'Informed Consent: What Does It Mean?' (1983) 9 *Journal of Medical Ethics* 69.

[3] (1992) 109 ALR 625 at 633, [1993] 4 Med LR 79, in which Mason CJ said that 'nothing is to be gained by reiterating . . . the oft-used and somewhat amorphous phrase "informed consent"'.

[4] *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1984] QB 493 (CA), [1984] 1 All ER 1018, [1985] AC 871 (HL), [1985] 1 All ER 643.

America, and it has been accepted to a degree in certain Commonwealth jurisdictions, although not in England or Scotland or South Africa.

Those jurisdictions which accept the doctrine are said to have adopted an approach favourable to the patient in any dispute, while those which do not tend to favour the physician. But the position is in flux in this regard. What this article argues is that with the attitude of South African courts as close to that of England as it is, certain conclusions can be drawn and predictions made by considering discussions of this topic elsewhere in the Commonwealth. It will thus be constructive to begin with a discussion of the doctrine of informed consent as articulated by Commonwealth courts before considering possible developments in England and in South Africa.

Legal consent, notes Elaine Scarry, has attached to it facets of contract, signature, partnership, promise, waiver, warranty and elements of the relationship between the subject and property.[5] She considers consent in surgical operations in terms of consent to injury and violation, quoting Judge Cardozo in *Schloendorff v Society of New York Hospitals*,[6] who considered that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'.[7]

II INFORMED CONSENT AND THE *BOLAM* TEST

Since Roman law times,[8] freedom of agreement has been held in high esteem, because it derives from freedom of the will. Accordingly, in all agreements there has been established in law a need for unforced and informed consent as a declaration of willingness, which gains greatly enhanced importance with regard to invasive medical procedures. The absence of information (whether through deliberate or negligent omission) vitiates the will and could give rise to a legal cause of action.

In medicine, one can detect a move away from the prior, tacit or general consent described by classical liberalism to a more specific consent for each procedure, as well as a duty of information, which is in part due to the increasing complexity of medical procedures. For medical interventions, consent means a voluntary decision made by a competent person on the basis of adequate information.

The doctrine itself is derived from the need to take courage in pre-anaesthetic medicine,[9] but the basic rationale of the rule remains the primacy of patient autonomy. Autonomy in our context means that the

[5] Elaine Scarry 'Consent and the Body' (1990) 4 *New Literary History* 867; also quoted in B M Dickens *Justice Beyond Orwell* (Montreal: Les Editions Yvon Blais Inc 1985) 243.

[6] 211 NY 125, 105 NE 92 (1914) at 97.

[7] Ibid. Also *Canterbury v Spence* 464 F 2d 772 (1972) (US Court of Appeals, District of Columbia Circuit).

[8] Tony Honoré 'Hermogenianus on privity and the scope of the law of contract' (1991) 44 *Current Legal Problems* 135.

[9] *Slater v Baker and Stapleton* (1767) 2 Wils KB 359, 95 ER 860; *Kenny v Ledwood* (1932) 1 DLR 507 at 525.

patient is able, through the medical profession, to serve his or her own 'best interests' as he or she perceives them.[10]

Both English and American courts focus on patient autonomy, especially with regard to refusal of treatment, but the degree of dissemination of information is a point of divergence. In America, a doctor's duty required by courts in disputes is that of reasonable disclosure regarding the probable consequences and dangers falling within his knowledge.[11] Consent based on such disclosure can be said to have been informed, and the degree of disclosure required is a question for the court.

Complete consent, however, is impossible without information,[12] and the term 'informed consent' would appear redundant or self-justifying. But while consent will remain compulsory[13] for medical procedures, if it is not informed, then it is not true consent. However, the duty to inform is subject to certain exceptions[14] such as 'necessity',[15] which is always open to the physician and is assessed in England and Wales according to the *Bolam* test and in Scotland according to *Hunter v Hanley*.[16] It also applies to the concept of therapeutic privilege,[17] which is used as a counterargument in disclosure cases, but is constantly being eroded by the courts because it is not designed to be raised after the event and during litigation to excuse an oversight, but rather to excuse the physician in cases where, objectively assessed, disclosure would have been deleterious to the emotional state of the patient.

In *Re T (adult: refusal of medical treatment)*,[18] Lord Donaldson MR stated that 'law requires that an adult patient who is mentally and physically

[10] Dickens op cit note 5 at 244.

[11] *Williams v Meacham* 379 P 2d 292 (1963) (Supreme Court of Kansas).

[12] Other forms of consent are, however, possible, such as implied, tacit, or prior general consent. Implied consent, too, requires full prior knowledge (Syvil Lloyd-Morris 'The Age of Consent' (1991) 141 *New Law Journal* 426 (29 March 1991)) and covers circumstances of 'necessity'.

[13] In *Re S (adult: refusal of medical treatment)* [1993] Fam 123, [1992] 4 All ER 671, [1992] BMLR 69, however, the patient was operated upon without her consent in the interests of her unborn child.

[14] Examples are emergency, that it is the only course open (to which the patient could answer that he or she would have wanted a second opinion), that there is no chance of harm (this is unlikely to be the case factually, but it is my opinion that a physician should be obliged either to refer the patient for a second opinion or simply say that there is no risk).

[15] The requirements for a defence of necessity to succeed are that the patient is unconscious, has not previously expressed any objection to the form of treatment proposed and that what is done is the minimum required to save life.

[16] 1955 SC 200 at 206, in which the judge directed the jury that the test is whether there had been such a departure from normal and usual practices of general practitioners as could reasonably be described as 'gross negligence'. Deviation, therefore, is not in itself an indication of negligence.

[17] It has been argued that the physician has a right of non-disclosure vis-à-vis the patient which is based on the amount of knowledge and understanding about the general nature of the procedure which the patient is capable of gaining. Accordingly, doctors need not warn of everyday risks attendant to surgical procedures (at the one end of the scale) or (at the other) of procedures which the particular patient is incapable of understanding. This is also subject to objective testing in Canada: see Dickens op cit note 5 at 259.

[18] [1993] Fam 95 (CA), [1992] 4 All ER 649 at 653; *sd* (1992) 9 BMLR 46 (CA).

capable of exercising a choice *must* consent if medical treatment of him is to be lawful'. As a result of a valid consent, certain possibilities (such as tortious liability) are excluded. The use of the law of contract in such cases is rare, yet possible, at least in theory.[19] However, in 'the great majority of cases, the duty owed . . . towards the patient is the same whether there exists a contract or not . . . [because it] . . . arises out of the duty of care'.[20]

An action for trespass against the person or for battery is a further possibility.[21] This is the preferred option in America, in which lack of informed consent gives rise to an action in trespass, thereby conflating the torts of medical negligence and medical trespass. In England, however, it was held in *T v T*[22] that the surgeon operating without any consent at all commits battery against his patient,[23] but that imperfect consent could amount to negligence.

From the case law it is clear that an action in negligence is the dominant cause of action. It involves a departure from general and approved medical practice[24] and is based on things said and not said.[25] In *Reibl v Hughes*[26] it was pointed out by the Supreme Court of Canada that the courts' tendency in situations of non- or insufficient disclosure[27] of inherent risks is to consider negligence rather than battery, except in circumstances of fraud or misrepresentation.[28] Accordingly, the health carer will not incur liability in negligence unless it is established that he or she owed a legal duty of care to the patient and was in breach of that duty, and that as a consequence the patient suffered damage. Inadequate disclosure thus has to be the cause of the plaintiff's injuries. Because damage is a necessary element of the claim, the burden of proof rests with the

[19] According to *Van Wyk v Lewis* 1924 AD 438 at 455, the issue can often be considered in contract or in delict, but it remains a duty to exercise the appropriate care. See also *Daniels v Burfield* AUST SASC 1769 at 1790.

[20] H L Lord *Medical Negligence* (1957) 15.

[21] *Chatterton v Gerson & another* [1981] QB 432, [1981] 1 All ER 257, in which the concept of battery was considered. Bristow J held that the negligent failure to disclose inherent risks would not, in itself, vitiate consent. This was followed in *Hills v Potter & another* [1983] 3 All ER 716 at 728, [1984] 1 WLR 641 at 653 and in *Sidaway* op cit note 4.

[22] [1988] Fam 52, [1988] 1 All ER 613.

[23] According to *Attorney-General's Reference (No 6 of 1980)* [1981] QB 715 (CA), [1981] 2 All ER 1057, one cannot consent to battery. This was upheld in *Collins v Wilcock* [1984] 1 WLR 1172, [1984] 3 All ER 374. This paper, however, is considering ill-informed consent rather than general non-consent, although the categories do at times overlap.

[24] *Clark v MacLennan* [1983] 1 All ER 416.

[25] *Daniels v Burfield* op cit note 19 at 1771f.

[26] (1981) 114 DLR (3d) 1.

[27] Disclosure requirements from Canadian case law are based on the prognosis of the patient, accessible alternatives and benefits, success and failure rates, known effects and risks, materiality, the patient's means of inquiry and the physician's recommendation. Dickens op cit note 5 at 254–5.

[28] In *Hadley v Allou et al* (1985) 53 OR (2d) 419 at 423, McKinlay J of the Ontario High Court commented on 'informed consent' as analysed in *Reibl v Hughes*, saying that '[i]n such a case, the plaintiff could only know the "fact or facts upon which he alleges negligence", when he discovers that the results of the procedure performed were different from what the surgeon had led the patient to believe it would be and at that point could possibly assert misrepresentation'.

plaintiff to show that had he or she been warned of the risk which eventuated, he or she would not have undergone the treatment and therefore would not have suffered the injury of which he or she complains.

The two component parts of the informed-consent issue were succinctly stated in Canada by Hoyt JA in *Kueper v MacMullin*:[29] was the risk one which ought to have been disclosed to the patient and, if so, would a reasonable person, after having been fully informed of the risk, have consented to the procedure? In Australia, in *Daniels v Burfield*,[30] the plaintiff alleged that prior to the operation the defendant 'failed to obtain the plaintiff's informed consent to it'. The plaintiff alleged that had he been informed of the risk involved, he would not have had the operation. However, he failed to discharge that burden of proof and his claim accordingly failed. Similarly, in Canada in *Kitchen v McMullen*[31] the trial judge concluded that in this case even if the risk were to have been disclosed, the plaintiff would still have given his informed consent, because surgery was necessary.

The standard of the legal duty of care vis-à-vis information in the United Kingdom is a physician-based one. It has been rejected in Canada and Australia but not elsewhere in the Commonwealth, and is being eroded in the United Kingdom[32] and South Africa. The *Bolam* principle, as outlined with approval in *Sidaway*, 'may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice adopted at the time as proper by a responsible body of respectable medical opinion'.[33] In short, the law imposes a duty of care: but the standard of care is a matter of medical judgement. In *Moyes v Lothian Health Board*,[34] in supporting the above two cases, the Court of Session of Scotland held that 'it was not the law that the informed consent of a patient had in all circumstances to be obtained. Rather, any warning to be given to a patient was to be governed by medical criteria unless it could be established as necessary in reliance on the general duty to show care.' In fact, Dunn LJ stated in *Sidaway*[35] that the 'doctrine of informed consent has no place in English law'. Scottish and English courts are reluctant to hold medical professionals responsible, and are out of step with developments in Australia and Canada, as well as with the Patients Charter of 1992.[36]

There is a difference here between consenting to treatment and refusing it. Dickens, however, argues that with the exception of the law of

[29] (1986) 30 DLR (4th) 408 at 412 (New Brunswick Court of Appeal).

[30] Op cit note 19.

[31] (1989) 62 DLR (4th) 481 (New Brunswick Court of Appeal).

[32] In *Sidaway*, only Lord Diplock accepted the *Bolam* principle without modification. All the other law lords, while accepting it in principle, preferred a more patient-oriented test.

[33] McNair J op cit note 1.

[34] [1990] SLT 111 at 119, [1990] 1 Med LR 163 at 169, per Lord Caplan.

[35] [1984] QB 493 (CA) at 517B–C, [1984] 1 All ER 1018 at 1030*h–i*.

[36] P Baleh 'Consent to Medical Treatment' (1994) 138 *Solicitors Journal* 121–3 (11 February 1994).

battery, 'the decision to decline treatment is no different from the decision to accept treatment'.[37] But in my view, while the salient point of the matter is whether any decision regarding treatment is adequately informed, it is doubtful whether the degree of disclosure of information required would be as high in cases where the patient refuses treatment on the basis of insufficient information and a risk associated with non-treatment eventuates; or that causation (in terms of remoteness of damage) in such a case would be as easily proved.[38] In line with this view, in *Haughian v Paine*[39] it was held by the Saskatchewan Court of Appeal that in order to enable a patient to give informed consent to surgery, in addition to disclosing the material risks of the surgery a surgeon must explain to the patient the consequences of leaving the ailment untreated, as well as the alternative means of treatment and their risks. This indicates that in both situations the duty is present, but not that the obligation is of equal extent.

In *White v Turner*[40] the Ontario High Court of Justice extended *Reibl v Hughes* to some degree in holding not only that material risks as well as unusual risks should be disclosed but that there is an overlap between these two categories. With the advantage of hindsight, a plaintiff would be more easily able to assert that he or she would not have undergone the procedure. Accordingly, the decision of the Supreme Court of Canada in *Hopp v Lepp*[41] asserts that the issue is whether the reasonable person in the plaintiff's position would have declined or accepted treatment, given the information available at the time and excluding the advantage of hindsight.

Rogers v Whitaker demonstrated a move towards more objective testing of the informed-consent issue in Australia, although, following England, the subjective test has traditionally been employed.[42] The case turned on whether the amount of information the doctor had disclosed complied with the standard of care which could reasonably be expected of him. The court held that notification should have been given of a one in 14 000 risk in the case of the patient in question (of developing sympathetic opthalmia during eye surgery). Significantly, the defence relied on *Bolam*, but the court rejected that reliance by distinguishing between diagnosis or treatment and information; it also held that evidence of acceptable medical practice serves only as a useful guide to the courts,

[37] Dickens op cit note 5 loc cit.

[38] It has, however, been held in America in *Cobbs v Grant* (see Dickens op cit note 5 at 215) that if a patient indicates a desire to refuse treatment, then the risks associated with non-treatment should be explained.

[39] (1987) 37 DLR (4th) 624 (Saskatchewan Court of Appeal).

[40] (1981) 120 DLR (3d) 269 (Ontario High Court of Justice).

[41] (1981) 112 DLR (3d) 67, which was supported in *Reibl v Hughes* (1981) 114 DLR (3d) 1 at 13 (in fact Laskin CJC was on the bench in both cases) and advanced an objective disclosure test.

[42] The Supreme Court of South Australia has adopted the subjective approach in *Gerrer v State of South Australia and Perriam* (1986) 39 SASR 543 at 566, *Ellis v Wallsend District Hospital* (1990) 2 Med LR 103 (CA) and *Hv Royal Alexandra Hospital* (1990) 1 Med LR 296

whose prerogative it remains to determine the appropriate standard of care with regard to disclosure of information. The plaintiff successfully argued that the *Bolam* principle should not be applied if it entails that courts would defer to the medical experts in medical-negligence cases, and that the primary judge was correct in the circumstances of this case in not deferring to the views of those medical practitioners who gave evidence that they would not have warned the plaintiff. In the context of advice and information given to patients, wherever courts assert their own primacy over medical practice, therefore, the *Bolam* standard is being eroded.

In cases of alleged medical negligence the plaintiff cannot know any fact concerning the alleged breach of duty until he or she has at least some information that the surgeon did not act in accordance with the standard of care required of surgeons.[43] And he or she can only get this information from other medical professionals. It is at this point that expert medical witnesses become important in any matter. In this regard, the New South Wales Court of Appeal had in *Ellis v Wallsend District Hospital*[44] adopted a more patient-centred approach than *Sidaway*. The Court held that medical opinion and standard practices are important, but as a guideline to the court; as in *Rogers v Whitaker*.

The *Sidaway* case concerned a patient who was not told of a chance of about one per cent that spinal damage might result from an operation on her neck. That chance eventuated. The House of Lords confirmed the *Bolam* test with regard to disclosure of inherent risks. It did, however, rule that medical opinion was not decisive and retained the right to overrule it if disclosure was obviously necessary to an informed decision by the patient. Lord Bridge indicated that circumstances might arise where the court might reject the standard of accepted medical practice, thereby indicating a further erosion of *Bolam*. Lord Templeman agreed and said that the court would determine whether the doctor had 'blundered' in not disclosing information. The court in *Gordon v Wilson & others*,[45] considering *Sidaway* and *Moyes*, attached particular weight to the speech of Lord Bridge, which was made in response to comments of Laskin CJC in *Reibl v Hughes* in which the latter distinguished the informed-consent case from cases involving the question whether the doctor had carried out his professional activities by applicable professional standards.

Lord Scarman, dissenting in *Sidaway* after considering *Canterbury v Spence*,[46] the leading United States authority on the subject, as well as *Reibl v Hughes*, would have found the doctrine of informed consent to be the law in England. He stated:[47]

[43] *Lewis v De Villiers* (1992) Ont CJ 332 at 345.

[44] (1989) 17 NSWLR 553, cited in Dieter Giesen & John Hayes 'The Patient's Right to Know — A Comparative View' (1992) 21 *Anglo-American LR* 101 at 106.

[45] [1992] SLT (NOTES) 849. [46] Op cit note 7.

[47] [1985] AC 871 (HL) at 888D–E, [1985] 1 All ER 643 at 654*b–d*

'My Lords, I think the *Canterbury* propositions reflect a legal truth which too much judicial reliance on medical judgment tends to obscure. In a medical negligence case where the issue is the advice and information given to the patient as to the treatment proposed, the available options, and the risk, the court is concerned primarily with a patient's rights. The doctor's duty arises from his patient's rights.'

Sidaway adopted a paternalistic and physician-oriented approach, and aligned informed consent with professional duty; yet it did not leave the issue in the hands of the medical profession alone. *Bolam*, it should be noted, was only a decision of first instance, and what has become the *Bolam* test was part of the summing-up to a lay jury.[48] But, though divided on its adequacy, the House of Lords supported it in *Sidaway*.

Lord Scarman in *Sidaway* was of the view that the *Bolam* test was a dilution of the very basis of the principle of consent: patient autonomy. In *Rogers v Whitaker*, for instance, there was also evidence from similarly reputable medical practitioners that they would have warned of the 1:14 000 risk. However, according to Iain S Goldrein, '[it] is so easy to confuse the calibre of the witness with the calibre of the opinion he professes to hold', and so courts have developed rules by which expert opinion is assessed: if the opinions of one group of physicians are clearly unreasonable, that is, that such views would not be held by any reasonable body of doctors, they can be disregarded.[49]

Common practice, however, still plays its most conspicuous role in actions based on alleged medical negligence.[50] The Court of Session of Scotland in *Moyes v Lothian Health Board*[51] considered practices varying between practitioners and affirmed that a failure to warn of risks was always to be judged by practitioners' standards. The question as to what constitutes negligence is answered through the application of *Bolam*, which is being seen as increasingly inappropriate. The alternative, gaining popularity in the Commonwealth, is the standard of what the reasonable patient in the particular patient's position would want to know, as is the test set out in Canada in *Reibl v Hughes*.[52]

According to the Law Reform Commission of Canada in 1980,[53] all material or relevant facts which could influence the patient's decision whether to undergo treatment should be disclosed. The test for materiality is to be objective, but is to become subjective to the extent that the

[48] It is considered too archaic to be applicable in tort cases nearly four decades after the decision. See Iain S Goldrein '*Bolam*—Problems Arising Out of "Ancestor" Worship' (1994) 144 *New LJ* 1237 (16 September 1994).

[49] Op cit note 48 at 1315 (30 September 1994).

[50] *E v Australian Red Cross Society & others* (1991) 99 ALR 601 at 650.

[51] [1990] SLT 444, [1990] Med LR 463.

[52] It was held that the court or the jury may assess what the reasonable patient would have wanted to know. In contrast, British courts maintain a professional standard of care, which has the drawback of placing too much power in minority opinion and not taking into account non-medical, patient-oriented factors. This was confirmed in *White v Turner* (1981) 120 DLR (3d) 269 (Ontario High Court of Justice), according to which the court has to be satisfied as to what the reasonable patient in the same situation would have done or wanted.

[53] *Consent to Medical Care*. Law Reform Commission of Canada, 1980. Kirby op cit note 2 at 71.

physician knows the patient and as a consequence expectations of the physician are raised.

There are three possible standards which can be adopted, but it remains a question of whose interests are being represented in any form of testing elected. The medical-professional standard was accepted by English courts in *Bolam* and *Sidaway*. The subjective-patient standard, according to which each specific patient would have to attest to whether he or she would have made a certain decision given the disclosure of risks, has been criticized for being prone to hindsight and to the whims of the unreasonable patient, and because it would not be practically possible to handle all patients identically and with a view to fairness under a subjective test.

The objective test is more practically operable. It disposes of the problem of hindsight by asking how the average prudent person in the plaintiff's situation would have decided, given the circumstances. It also dispenses with the problem of holding a practitioner liable for the whimsical courses of action of his or her patients under the subjective test. The plaintiff's apparent desire for knowledge comes increasingly into play as indicative of what the physician should objectively have known of the patient's informational needs. Account is to be taken of the particular patient's position, objectively assessed. If, for example, the patient indicates a clear concern of a certain nature and a general inquisitiveness, as occurred in *Rogers v Whitaker*, the reasonable physician could be expected to know that he or she would want to be informed of any such risk. In this instance, it was held that because Mrs Whitaker had shown a general concern regarding damage to her 'good' eye during surgery, the reasonable surgeon ought to have appreciated that (because the lay person cannot appreciate the vagaries of sympathetic opthalmia) this particular patient would have wanted to be warned of such a risk. Under the objective test it is reasonable to contend that the physician ought to know that the seriousness of inherent consequences is directly proportional to the patient's desire for information. Even a slight risk, given the obvious interest and interests of the patient, is warnable under the objective and apparent-subjective tests.[54] Similarly, the court in *Reibl v Hughes* held that objectively appraised, the patient's particular situation decreases the force of the physician's recommendations.[55]

In the requirement to 'ask the right questions' in English law, the onus of inquiry is placed on the patient, and the obligation on the doctor is only

[54] *Reibl v Hughes* supra note 41 formulated a modified objective test for causation to be applied in informed consent cases. At 16 Laskin CJC stated that '[t]he adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it. . .'

[55] Ibid

increased in the case of an inquisitive patient.[56] According to Balen,[57] '. . . a doctor needs to ask the question "is the level of capacity demonstrated by the patient commensurate with the gravity of the decision to be taken in giving or refusing consent?"' Only if the answer is 'no' should paternalistic principles be invoked; yet the problem will remain the *Bolam* standard employed in answering the question: the capacity of the patient to understand is professionally assessed and that professional assessment is then judged according to *Bolam*.

According to the Canadian Law Reform Commission, the test of comprehension should be apparent-subjective, with the onus on the physician to take reasonable steps with regard to the particular patient to ensure understanding. Miller[58] notes that since 1988 the British Medical Association, too, has changed its emphasis in doctor-patient relations from paternalism to partnership. Paternalism (in the form of the *Bolam* test) is under increasing pressure in the United Kingdom. This is further evident from the National Health Service Patients' Charter of 1991,[59] which states that every citizen has the right 'to be given a clear explanation of any treatment proposed, including *any* risks and alternatives'.[60]

But there are trends which would appear to be going in the other direction. In *Re S*[61] the beginnings of a slippery slope are evident from the non-consensual abortion performed on S during a hysterectomy. This indicated that it is at least theoretically possible that a competent woman's decision could be disregarded, thereby on the face of it decreasing patient autonomy.

What has become apparent is that, in respect of the *Bolam* test, there is a difference between treatment and information. Because as a general rule the judiciary lacks medical expertise, *Bolam* is only able to be eroded in the courts in respect of the standards of disclosure of inherent risks that are to be required of physicians by the law. In *Sidaway*, it was not presumed that the standards applicable to diagnosis and treatment should be the same as those applied to disclosure.[62] Similarly, in *Rogers v Whitaker* this difference was acknowledged.[63] What emerges is an isolation of the advisory duty from diagnosis and treatment, and it is at that point at which the *Bolam* standard is being eroded to varying degrees across the Commonwealth.

[56] Balen op cit note 36 at 121. Certainly, in most cases involving inadequate warning, the plaintiff failed to ask specific questions. Where he or she does ask such questions, he or she is entitled to a full answer, as was held in three jurisdictions in *Sidaway*, *Rogers v Whitaker* and *Reibl v Hughes*.

[57] Balen op cit note 36 at 122.

[58] F H Miller 'Denial of Health Care and Informed Consent in English and American Law' (1992) 18 *American Journal of Law and Medicine* 37.

[59] Miller op cit note 58 at 69.

[60] The Patients Charter 1992, 9; my emphasis. This is agreed with by M Dean *The Lancet* 341 (April 1993) 883; quoted by Balen op cit note 36, as well as by the Medical Defence Union in the United Kingdom.

[61] *Re S (adult: refusal of medical treatment)* [1993] 1 am 123, [1992] 4 All ER 671, [1992] BMLR 69.

[62] [1984] QB 493 (CA) at 513, [1984] 1 All ER 1018 at 1028.

[63] *Rogers v Whitaker* (1992) 109 ALR 625 at 632.

South Africa has hitherto followed the position as expressed by the English courts. When confronted with the question in *Blyth v Van den Heever*[64] as to what constitutes negligence in the medical arena, Corbett JA set out a *Bolam*-style test, albeit in the therapeutic context. In terms of disclosure of information, the court in *Lymbery v Jefferies*[65] held that it is not necessary to inform a patient of all complications which could arise and that '[t]here should have been some evidence for the inference that if the explanations as to the danger of the treatment had been given she would have refrained from the treatment'. The benchmark case in medical negligence in this country continues to be *Van Wyk v Lewis*,[66] in which it was accepted that the degree of skill to be expected is that customarily adopted by the relevant branch of the profession concerned and not the highest possible degree. These are decisions which were to have been expected in 1924 and 1925 when our law and English law were very much closer than they are today (although at that stage *Van Wyk v Lewis* drew heavily on American decisions) and when the issue of disclosure was not high up on the agenda.

These cases continue to gain approval in our courts with regard to standards of treatment. Some erosion, however, can be detected regarding disclosure of inherent risks. In *Richter & another v Estate Hammann*,[67] Watermeyer J recognized that failure to disclose risks may amount to negligence.[68] Considering the doctor's dilemma, the learned judge said:

> 'It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem. In reaching a conclusion a court should be guided by medical opinion as to what a reasonable doctor, having regard to all the circumstances of the particular case, should or should not do. The court must, of course, make up its own mind, but it will be assisted in doing so by medical evidence.'[69]

In making up its own mind and 'retain[ing] judicial sovereignty over the expert evidence',[70] the court asserts itself and erodes *Bolam*. Here, the Cape Provincial Division might be considered to be leading towards the situation which was to be outlined in *Reibl v Hughes* and *Canterbury v Spence*. The nature and extent of the duty to warn a patient of consequences of a surgical procedure as outlined in *Richter v Estate Hammann* were affirmed in *Castell v De Greef*[71] as embracing the normal and expected consequences.

In *Castell v De Greef* the Cape Provincial Division discussed the doctrine of informed consent more fully. Significantly, Scott J affirmed both *Sidaway* and *Bolam*, noting that the House of Lords in *Sidaway* had declined to adopt *Reibl v Hughes* or *Canterbury v Spence* and instead had reaffirmed *Bolam*. Scott J stated that 'there can be no justification for

[64] 1980 (1) SA 192 (A) at 220–1.

[65] 1925 AD 236 at 238, 240.

[66] 1924 AD 438. Supra note 19.

[67] 1976 (3) SA 226 (C).

[68] Supra note 67 at 232G–in fine.

[69] This was approved by *Castell v De Greef* 1993 (3) SA 501 (C) at 517I–11.

[70] Goldhein op cit note 18 at 1378 (7 October 1994).

[71] *Castell v De Greef* supra note 69 at 517.

adopting [the doctrine established by *Reibl v Hughes* and *Canterbury v Spence*] in our law'.[72]

However, on the basis of the above argument that in *Sidaway* and *Richter* one can detect an erosion of the *Bolam* principle with regard to disclosure standards in the same way, although less dramatically, in which it has been eroded in Australia in *Rogers v Whitaker* and more so in *Reibl v Hughes* in Canada, and considering the proximity of the genesis of those two systems with our own and from English law, it is apparent that it is only a matter of time before such a doctrine becomes accepted law in South Africa. *Richter* opened the door to the prudent-patient standard which, in my view, will better fit the new legal climate in this country in which the common person is given priority, and in which it can be likened to the socialism of Australia, the welfarism of Canada, and the constitutional climate of America. Courts have asserted dominance over the medical profession and have adopted *Sidaway* together, it can be inferred, with its qualifications of *Bolam*, from which I argue that to affirm both *Sidaway* and *Bolam* in toto is incoherent.

III CONCLUSION

The law in both Scotland and England has come down firmly against the view that the doctor's duty to the patient involves at all costs obtaining the informed consent of the patient to specific medical treatments.[73] But when the patient entrusts himself to the doctor he expects, and is entitled, to be kept fully informed about decisions which have to be taken and which may concern his welfare, even if the doctor is considered to know best.

Commonwealth countries are divided[74] on the issue whether to adopt a subjective physician-based standard or a more objective patient-based standard, according to their degree of acceptance or rejection of *Bolam*. The difference is between the reasonable doctor and the prudent patient. Current trends would seem to indicate that the *Bolam* standard is archaic. In *Sidaway* four of the five law lords preferred a more patient-oriented

[72] Supra note 69 at 518B–J.

[73] Lord Caplan in *Moyes v Lothian Health Board* [1990] SLT 444 at 449, [1990] 1 Med LR 163 at 467.

[74] The pivotal point here is the adoption or rejection of the *Bolam* test. Certainly England retains it with some qualifications and Australia and Canada do not. New Zealand would appear to follow *Bolam*, as was indicated in the admittedly non-medical case of *Kendal Wilson Securities Ltd v Banadough* [1986] 1 NZLR 576 at 584 as well as in the passive euthanasia case of *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, which relied to some extent on 'good medical practice' in declaring withdrawal of ventilation lawful. In southern Africa the standard of care in medical cases is still paternalistic and follows *Bolam*. (Other than the cases already cited, see P Q R Boberg *The Law of Persons and the Family* (1977), *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) and *Correia v Benvind* 1986 (4) SA 60 (Z).) In India, patients still, despite a lobby to change this position, fall under the Consumer Protection Act and, as such, negligence is a procedural rather than a substantive matter. An action involves a summary hearing before judges and social workers on district, state and national levels. Under this Act a professional standard of care is applicable.

standard, including disclosure of information regarding material or substantial risks; information with which the disadvantages and dangers are communicated as well as full and truthful responses to questioning by patients.[75] Lord Templeman spoke of the need for information standards suitable to a balanced judgement, saying that he '[did] not subscribe to the theory that the patient is entitled to know everything nor to the theory that the doctor is entitled to decide everything',[76] thereby positioning himself somewhere between autonomy and paternalism. In this way, the House of Lords in *Sidaway* adopted the American doctrine into the English law of negligence in a reduced form.

If legal negligence is based on a professional standard, that standard might be prone to lowering in order to protect the profession from within: the 'conspiracy of silence' described by several authors and judicial opinions.[77] For this reason, among other reasons, proponents of the objective test[78] advocate a 'prudent patient' test, and the physician-based standard is becoming less and less decisive, which is cause for optimism. In *Daniels v Busfield* and *Rogers v Whitaker* the Australian High Court followed *F v R*[79] and categorized it as an 'informed consent' case in which, three years after *Sidaway*, King CJ rejected the conclusiveness of evidence of accepted practice. Judges would remain under no obligation to scrutinize medical practices, because that is outside of their realm of expertise; but they can consider the category of reasonableness and the amount of information required by patients.

Mason CJ in *Rogers v Whitaker* saw informed consent as an ideal to which practice can only aim. It is impossible to convey to the patient all the medical knowledge of the trained physician, such that consent will be imperfect to the extent that it is ill-informed. Indeed, in *Castell v De Greef* the Cape Provincial Division applied *Lymbery v Jefferies*,[80] in which the Appellate Division held that it is not necessary to inform a patient of all complications which could arise from a given procedure. As Mr Justice Kirby put it, 'the very notion of informed consent implies a sophistication on the part of the patient',[81] and if a patient is genuinely unable to comprehend, then autonomy is nebulous anyway and the patient will fall under the applicable Mental Health Act or Children Act.

The doctrine of informed consent suggests that a doctor's role is simply to inform, whereas knowledge of the patient should be the emphasis. In communication terms, this would mean that ideally the practitioner would take steps to become aware of how much information the patient

[75] R Gillon 'Consent' (1985) 291 *British Medical Journal* 1700 at 1701.

[76] [1985] AC 871 (HL) at 904A–B, [1985] 1 All ER 643 at 665*h–i*.

[77] *F v R* (1983) 33 SASR 189 at 194, per King CJ.

[78] Such as Ian Kennedy 'The Patient on the Clapham Omnibus' (1984) 47 *Modern LR* 451.

[79] Op cit note 77 at 191.

[80] Supra note 65 at 240.

[81] Kirby op cit note 2 at 73.

requires for his or her decision to have been adequately informed.[82] The standard in *Reibl v Hughes* is that the normal intelligent patient would want an objectively reasonable explanation of the risks involved according to a patient-based standard. In my opinion this middle ground between the American vitiation of consent giving rise to an action in battery and the physician-based gospel according to *Bolam* and *Sidaway*, the middle ground that has become the standard in Canada and Australia, is to be preferred as the 'right approach'.[83]

Regrettably, however, in *Hills v Potter* Hirst J and in *Castell v De Greef* Scott J each rejected the argument that he should follow the Canadian cases, and applied *Bolam*. Clearly *Rogers v Whitaker* has moved closer to Canada with regard to the objective test, and in England *Sidaway* does not conclude that debate. Erosions of the professional standard are apparent such that, as with Hamlet, the decision regarding the preferable state of being has been preordained. This is because, when it comes to informing patients of inherent risks, the professional standard falls short of the ethical premiss of autonomy and because the judgments in *Sidaway* in England and *Richter v Estate Hammann* in South Africa now demand it through qualifications of *Bolam*.

JUDICIAL LAWMAKING

'It is hard, when discussing the propriety of judicial law-making, to reason conclusively from one situation to another. . . . I believe, however, that one can find in the authorities some aids to navigation across an uncertainly charted sea: (1) if the solution is doubtful, the judges should beware of imposing their own remedy; (2) caution should prevail if Parliament has rejected opportunities of clearing up a known difficulty or has legislated while leaving the difficulty untouched; (3) disputed matters of social policy are less suitable areas for judicial intervention than purely legal problems; (4) fundamental legal doctrines should not be lightly set aside; (5) judges should not make a change unless they can achieve finality and certainty': per Lord Lowry in *C v Director of Public Prosecutions* [1995] 2 All ER 43 (HL) at 52.

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[82] See F F W Oosten 'Disclosure Documents and Informed Consent: The Pros and Cons' (1993) 12 *Medicine and Law* 651–6, in which Van Oosten appreciates the role which individuality has to play.

[83] *Videto v Kennedy* (1981) 125 DLR (3d) 127 (Ontario Court of Appeal) at 133. Cited in Dickens op cit note 5 at 256–7.

COUNCIL OF EUROPE

SECRETARIAT GENERAL

APPENDIX B

Please quote :

Dear Mr Earle,

I would like to inform you that no book setting out the rationale of each clause of the Convention on human rights and biomedicine has been published. The document containing the preparatory work of the Convention is still classified as restricted, so that we cannot distribute it.

Canada, Australia and the United States have observer status within the Steering Committee of Bioethics (CDBI) which has drafted the Convention. Consequently, these countries took part into the process of the elaboration of the Convention.

The concept of "informed consent" must be interpreted according to national law. The explanatory report gives some informations about its meaning (paragraph 35). Drafted under the responsability of the Secretariat, it reflects the opinion of the Committee but is not a binding instrument.

Concerning your last question, please refer to chapter XI of the Convention, which deals with this issue.

I hope that above information will help you in your work.

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